Dr. Curtis Roy & Assoc.
3703 Johnston Street
Lafayette, LA 70503

Patient Information/Medical History

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (it different): _____ City: _____ State: _____ Zip: _____

Home phone _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____

SS #: _____ Employer: _____ Bus. Phone: _____

Spouse's name & phone #: _____

Person to contact in case of emergency: _____ Phone: _____

Primary dental insurance: _____ Group ID #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Heart Stint	☐	☐
Blood Problems	☐	☐
Allergy Problems	☐	☐
Intestinal Problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Premedications required by physician	☐	☐
Cancer (Tumor)	☐	☐
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? _____		
Do you smoke?	☐	☐
If so, how much? _____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐

	Yes	No
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐

If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following?

Local anesthetic (Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber gloves	☐	☐
Other _____		

During the past 12 months, have you taken any of the following:

Antibiotics or sulfa drugs	☐	☐
Blood Thinners (i.e., Coummadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other _____		

Women

Are you pregnant?	☐	☐
If so, expected delivery date _____		
Are you nursing?	☐	☐

Medications

Please indicate if you have taken any of the below mentioned medications in the past or if you are currently taking these medications.

	Yes	No
Pamidronate (Intravenous) **(Aredia,** Novartis**)**	_____	_____
Zoledronate (Intravenous) **(Zometa,** Novartis**)**	_____	_____
Etidronate (Oral, Intravenous) **(Didronel,** Proctor & Gamble**)**	_____	_____
Risedronate (Oral) **(Actonel,** Proctor & Gamble**)**	_____	_____
Tiludronate (Oral) **(Skelid,** Sanofi**)**	_____	_____
Alendronate (Oral) **(Fosamax,** Merck**)**	_____	_____
Ibandronate (Oral, Intravenous) **(Boniva,** Hoffmann-La Roche**)**	_____	_____

"Because you are taking a type of drug called a bisphosphonate, you may be at risk for developing osteonecrosis of the jaw and certain dental treatments may increase that risk."

Please list all medications you are currently taking (both prescribed and over the counter). Use reverse side for additional space.

_____

_____

_____

_____

_____

PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY.

The above information is true and complete to the best of my knowledge. I agree to pay my co-payment at the time services are rendered. The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature (Parent's signature, if a minor) _____ Date_____