



BARKLEY BOULEVARD DENTAL CARE

Last Name _____ First Name _____ Middle Initial _____
 Preferred Name _____ Preferred Pronoun _____ Birthdate _____
 Address _____ City/State _____ Zip _____
 Primary Contact Phone _____ Home / Cell / Work (please circle one)
 Email address _____

Please list all medications you are currently taking, including any we may have on record: _____ _____	YES / NO
Are you sensitive or allergic to any medications? If so, please list: _____	YES / NO
Have you ever taken bisphosphonates or other meds for Osteoporosis?	YES / NO
Have you used or do you currently use tobacco, zyn, marijuana, or vape? How Often? _____	YES / NO
Have you had joint replacements or heart surgery? _____ If yes, when? _____	YES / NO

Please circle to indicate which of the following you have had or have at the present.

Allergies or Hives	Allergy to Latex/ Metals	Anemia	Angina Pectoris
Anxiety / Depression	Arthritis	Artificial Heart Valve	Artificial Joints
Asthma	Auto Immune Disorder	Cancer	Chemotherapy
COVID 19	Crohn's	Cold Sores	Diabetes I / II
Epilepsy / Seizures	Fainting / Dizziness	Heart Failure (CHF)	Heart Surgery
Heart Attack	Heart Disease	Heart Murmur	Hepatitis A B C
High Blood Pressure	High Cholesterol	HIV positive / AIDS	Kidney / Liver Problems
Liver Disease	Mitral Valve Prolapse	Memory Loss / Dementia	Osteoporosis
Pacemaker	Rheumatic Fever	Radiation Therapy	Substance Abuse
Stroke	Thyroid problems		

Do you have or have you had any disease, condition or problem not listed? If so, please list: _____ _____	YES / NO
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For Women only:

Are you pregnant? YES / NO	Are you nursing? YES / NO	Taking birth control pills? YES / NO
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I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
 I have answered all questions truthfully and to the best of my knowledge.

Patient or Responsible Party Signature:

_____ Date: _____

Office use only: _____ B/P _____