Date: _______________

Patient's Name: ________________________________

Single ___**Married** ___ **Sep.** ___ **Div.** ___ **Widow** ____
Age _____ **Birthdate** ___________
SSN __________________**Telephone** _____________
Address _____________________________________
____
Cell no. ________________ **Work** ________________

e-mail ____
Employed by___________________________________
Name of spouse or parent ______________________
Emergency Contact ____________________________
Phone number: ________________________________

Attention:
Please let us know the name of the person who referred you to our office so that we may thank them.

Chief dental complaint:

If you have ever had any serious trouble associated with any previous dental treatment, please explain

Date of last medical Exam? ______________
What was it for?________________________
Have you been hospitalized in the last 5 yrs? Y N
If yes, reason:_________________________________
Are you currently receiving care? Yes No
Nature of care:

Name and phone number of physicians:
____
____
____
____
____
____

Y	N	Condition
		Abnormal Bleeding
		Anemia/Blood disorders
		Diabetes
		Sickle Cell Disease
		Angina Pectoris
		Congential Heart Defect?
		Congestive Heart Failure?
		Heart Attack, Heart Surgery, Heart stent? (when)
		Heart Valve(artificial), Transplant or Pace Maker?(when)
		Heart Murmur/ Mitral Valve Prolapse?
		High Blood Pressure
		Rheumatic Fever/ Bacterial Endocarditis?
		Stroke (when)
		Asthma
		Difficulty Breathing
		Emphysema/Respiratory disease?
		Hay Fever
		Tuberculosis
		Arthritis
		Hip/joint replacement (when)
		Cancer - Chemotherapy
		Radiation Therapy
		Colitis
		Ulcers
		Epilepsy/Seizures
		Fainting or Dizzy Spells
		Frequent Headaches
		Glaucoma
		Hepatitis (type)
		Liver Disease
		Kidney Problem
		Psychiatric, Emotional, Nerve Problems?
		Sexually Transmitted Disease
		Fever Blisters
		HIV + AIDS
		Sinus problems

Y	N	Condition
		Thyroid Problems
		Drug Abuse
		Have you ever had Cortisone Treatment?
		Have you ever undergone Surgery?
		Do you smoke/use tobacco/chew? How much: Do you want to quit?
		Any problems with dental injections?
		Have you ever taken Bisphosphonates (Fosamax, Aredia, Zometa, Actonel, Boniva?
		Do you have a Diagnosis of Sleep Apnea?

Are you trying to get pregnant? _________
Are you pregnant? _______ #wks _______
Are you taking Birth Control Pills? ______
Are you nursing? ____________

Are you allergic or have you had a reaction to:

a. Local anesthetics ………………… No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin, Ibuprofen or Tylenol …… No Yes
d. Codeine, Valium® or other ……… No Yes
e. Latex or Metals……..…………… No Yes
f. Other (please specify)____________________
____

Please list any disease, condition or problem you think this office should know about that is not covered above?

Please list any medications you are currently taking and dosages:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________

Signature: ______________________________
Date: ______________________

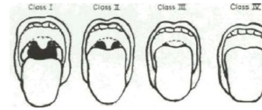
Date: _______________

Please list any dietary or herbal supplements you are taking,:

1. ____
2. ____
3. ____
4. ____

Today's BP: _______/_______ Pulse: __________ SPO2: ___________

Weight ________Height ________ BMI ______



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For Sedation Patients only:

Are you taking any of these Medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Dietary Restrictions:________________________

Food Allergies: ___________________________

Sugar in your diet: none slight moderate high

Doctor Comments: IV or Oral Sedation:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

Patient Signature: __________________________ Date: __________________ Doctor reviewed: _______________ Date: _________

Dental management considerations: