Medical Information

Although a dentist primarily treats the area in and around the mouth, your mouth is a part of your entire body. Health conditions that you may have or medications you may be taking, could have an important interrelationship with the care that you will be receiving.

Reason for today's visit: _____

Are you currently under a doctor's care? _____ Reason: _____

Doctor's name _____ Phone # _____

Have you had any illness, operation or been hospitalized in the last 5 years?

If so, describe _____

Do you have a prosthetic joint/implant, heart valve replacement or vascular graft? _____

Is so, how long ago _____

Has a physician or previous dentist recommended you take antibiotics prior to dental treatment?_____

Do you take, of have you taken Phen-Fen or Redux? _____

Have you ever taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates._____

Medications you are currently taking _____

_____

Pharmacy Name _____ Phone # _____

Women: Are you pregnant or trying to get pregnant? ____Yes ____No

Taking oral contraceptives? ____ Yes _____No Nursing? ____Yes _____ No

Are you allergic to any of the following: ___ Aspirin ___Penicillin ___Codeine ___ Local Anesthetics ___ Acrylic ___Metal ____Latex ____Sulfa drugs ____Erythromycin ___Tetracycline

Other If yes, please explain _____

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

----- AIDS/HIV Positive	**---- Diabetes**	**----- Hepatitis-C**	**----- Radiation Therapy**
----- Abnormal Bleeding	**----- Difficulty Breathing**	**----- Herpes**	**----- Rheumatic Fever**
----- Alcohol Abuse	**----- Drug Abuse**	**----- High Blood Pressure**	**----- Scarlet Fever**
----- Alzheimer's	**----- Emphysema**	**----- High Cholesterol**	**----- Seizures**
----- Anemia	**----- Epilepsy**	**----- Hypoglycemia**	**----- Shingles**
----- Angina	**----- Fainting Spells**	**----- Irregular Heartbeat**	**----- Sickle Cell Disease**
----- Arthritis/Gout	**----- Frequent Headaches**	**----- Joint Replacement**	**----- Sinus Problems**
----- Artificial Heart Valve	**----- Glaucoma**	**----- Kidney Problems**	**----- Stroke**
----- Asthma	**----- Heart Attack**	**----- Liver Disease**	**----- Thyroid Problems**
----- Blood Transfusion	**----- Heart Murmur**	**----- Low Blood Pressure**	**----- Tuberculosis**
----- Cancer/Chemotherapy	**----- Heart Surgery**	**----- Mitral Valve Prolapse**	**----- Ulcers**
----- Cold Sores/Fever Blisters	**----- Hemophilia**	**----- Osteoporosis**	**----- Venereal Disease**
----- Colitis	**-----Hepatitis-A**	**----- Pain in Jaw Joints**	
----- Congenital Heart Defect	**----- Hepatitis-B**	**----- Psychiatric Problems**	

Have you ever had any serious illness not listed above? _____

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay be less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or parent/guardian of minor **Date**