

**THE FOLLOWING DOCUMENTATION MUST BE AVAILABLE AT THE TIME OF BOOKING
FOR PATIENT TO COMPLETE**

Patient Name: _____ Date of Birth: _____ Gender: _____

Current/Primary Concerns: _____

Are you currently under the care of any other physician? Yes No , if yes, please list:

Name: _____ Phone number: _____

Name: _____ Phone number: _____

MEDICAL HISTORY:

Do you have sleep apnea, use CPAP or BiPAP? Yes No

Do you have a history of liver disease or chronic cirrhosis? Yes No

Do you become short of breath or develop chest pain when climbing two flights of stairs? Yes No

In the past two years have you required prolonged treatment with steroids? Yes No

Do you have high blood pressure that requires three or more medications to manage? Yes No

Have you ever had a blood clot, stroke, carotid artery blockage, or TIA (mini stroke)? Yes No

Are you currently taking blood thinners, such as Coumadin, Plavix, etc.? Yes No

Do you have diabetes that requires insulin treatment? Yes No

Do you have problems with excessive bleeding after surgical or dental procedures? Yes No

Do you have kidney problems (except for kidney stones or recurrent infections) that require treatment by a kidney specialist or are you on dialysis? Yes No

IMPLANTABLE DEVICE(S): No Yes, indicate type of device(s):

<input type="checkbox"/> Pacemaker/Defibrillator Year: _____	<input type="checkbox"/> Cardiac stent Year: _____	<input type="checkbox"/> Ventricular Assist Device Year: _____	<input type="checkbox"/> Insulin Pump Year: _____	<input type="checkbox"/> Other
---	---	---	--	--------------------------------

SURGICAL HISTORY: No Yes, list surgeries:

Year:	Type of Surgery/Procedure	Describe any Anesthetic Complications <i>(other than Nausea or Vomiting)</i>

MEDICATIONS: Not taking medication Yes, Please list all medications prescribed and over the counter

Medication	Dose	Frequency	Medication	Dose	Frequency
1			5		
2			6		
3			7		
4			8		

HEALTH HISTORY

Do you have a primary care physician? Yes No

Physician's name: _____

Phone#: _____ Last visit: _____

In the event of an emergency:

Name: _____

Relationship: _____

Home #: _____

Work #: _____

Pharmacy name and phone#: _____

Allergies:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other _____ |

Do you require premedication with antibiotics before dental treatment? Yes No

For what condition: _____

Do you or have you ever used:

- Tobacco?
Frequency _____
- Alcohol?
Frequency _____
- Controlled substances? Frequency _____

Women only:

Are you pregnant or trying to become pregnant? Yes

No Week _____

Are you taking birth control pills? Yes No

Are you nursing? Yes No

Hormone replacement therapy Yes No

Please check all that apply:

- AIDS/HIV
- ANEMIA
- ARTHRITIS OR RHEUMATISM
- ARTIFICIAL JOINTS
- ASTHMA

- BACK PROBLEMS
- BLEEDING ABNORMALLY
- BLOOD DISEASE
- CANCER
- CHEMICAL DEPENDENCY
- CHEMOTHERAPY
- CIRCULATORY PROBLEMS
- CONGENITAL HEART LESIONS
- CORTISONE TREATMENTS
- COUGH, PERSISTENT OR BLOODY
- CROHN'S DISEASE/INFLAMMATORY BOWEL DISEASE
- DIABETES (Please state type 1 or 2)
- EMPHYSEMA
- EPILEPSY
- FAINTING OR DIZZINESS
- GLAUCOMA
- HEADACHES
- HEART MURMUR
- HEART PROBLEMS
- HEPATITIS TYPE _____
- HERPES
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- IRRITABLE BOWEL DISORDER
- JAUNDICE
- JAW PAIN
- KIDNEY DISEASE
- LIVER DISEASE
- LOW BLOOD PRESSURE
- MITRAL VALVE PROLAPSE
- MULTIPLE SCLEROSIS
- NERVOUS PROBLEMS Please state: _____
- OSTEOPOROSIS/MEDICATIONS
- PACEMAKER
- PROSTATE PROBLEMS
- PSYCHIATRIC CARE
- RADIATION TREATMENT
- RESPIRATORY DISEASE
- RHEUMATIC FEVER
- SLEEP APNEA (C-PAP OR B-PAP)
- SHORTNESS OF BREATH
- SINUS TROUBLE
- SKIN RASH
- SPECIAL DIET
- STROKE
- SWOLLEN FEET OR ANKLES
- SWOLLEN NECK GLANDS
- THYROID PROBLEMS
- TMJ PROBLEMS
- TONSILLITIS
- TUBERCULOSIS
- TUMOR OR GROWTH ON HEAD OR NECK
- ULCER
- VENEREAL DISEASE
- WEIGHT LOSS, UNEXPLAINED
- PARKINSON'S
- HISTORY OF ORAL CANCER
- GOUT
- BENIGN ESSENTIAL TREMOR
- HPV HUMAN PAPILLOMAVIRUS
- AUTO-IMMUNE DISORDERS PLEASE STATE _____

The information on this page is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____Date_____