Medical Information Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, MI)	Today's Date ____/____/____		Age	Date of Birth ____/____/____	

Have you ever had any of the following? (**Check all that apply**)

_____Heart Problems
_____Heart Murmur
_____Pacemaker
_____Artificial Heart Valve
_____Artificial Joint
_____Rheumatic Fever
_____High Blood Pressure
_____Circulatory Problems
_____Blood Disease
_____Hemophilia
_____Stroke
_____Respiratory Disease/Asthma
_____Sinus Problems
_____Headaches
_____Thyroid Disease
_____Kidney Disease
_____Hepatitis, Jaundice or Liver Disease
_____Diabetes
_____Allergy to anesthetics
_____Allergy to medicines/Drugs
_____General Allergies
_____Ulcers
_____Special Diet
_____Back Problem
_____Arthritis
_____Tuberculosis
_____Epilepsy
_____Psychiatric Care
_____Chemical Dependency
_____Nervous Problem
_____Cancer
_____Radiation Treatment
_____Chemotherapy
_____Venereal Disease
_____AIDS or other Immuno Supressive Disorders

Do you have any drug allergies? _____Yes _____No If so, to which drugs?_____
_____
Have you ever had an adverse reaction to any medication?____Yes _____No
If so, what type of reaction?_____
Have you ever had an adverse reaction to local anesthetic?____Yes _____No
If so, what type of reaction?_____
Have you ever been pre-medicated with antibiotics prior to dental treatment? _____Yes _____No
Have you ever responded adversely to medical or dental treatment? _____Yes _____No
Are you taking any medication regularly? _____Yes _____No
If so, what prescriptions? _____
_____
Are you taking any over-the-counter medication regularly? _____Yes _____No
If so, what? _____
Are you taking any herbal supplements?____Yes____No If so, what?_____
Are you under the care of a Physician? _____Yes _____No
For What Conditions_____
Have you ever had periodontal treatment? _____Yes _____No
If yes, when? _____
By Whom? _____
Do you clench or grind your teeth? ___Yes ___ No Do you wear a night guard?___Yes___No
Do you have TMJ (jaw joint) problems? _____Yes _____No
Do you smoke or use other tobacco products? _____Yes _____No
Is there anything else we should know about your medical history? _____
_____
Women - Do you suspect that you are pregnant? _____Yes _____No
Are you nursing? _____Yes _____No

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

Signature ______________________________ Date ______________