PATIENT MEDICAL FORM

Family Name: _____ First Name: _____ (Mr / Mrs / Ms)

Date of Birth (Year/Month/Day): _____/____/____ Home Phone:_____

Gender: (circle) Male / Female / X Cell Phone:_____

Home Address:_____ Work Phone:_____

City:_____Postal Code: _____ Email:_____

Preferred method of contact to confirm appointments: ❑ Call Home # ❑ Call Cell # ❑ Call Work # ❑ Email ❑ Text Cell # ❑ Any

Medical History: (please check the yes or no boxes below)

Yes No

❑ ❑ Have you had a medical checkup within the last year? If not, indicate year of last check up: _____

❑ ❑ Have you ever had any general surgery? If so, explain: _____

❑ ❑ Have you been treated for any medical conditions within the last year? If so, explain:_____

_____

❑ ❑ Have you taken any medicine, pills or drugs within the past month? If so, list: _____

_____

❑ ❑ Have you ever been told by a physician (family doctor) that you require antibiotics before dental treatment for a medical condition or any reason? _____

❑ ❑ Do you have any conditions or therapies that could affect your immune system, such as Leukemia?_____

❑ ❑ Have you ever taken a Bisphosphonate medication such as Actonel (Risedronate), Aredia (Pamidronate), Benefos (Clodronate), Boniva (Ibandronate), Didronel (Etidronate) Fosamax (Alendronate), or Zometa (Zoledronic Acid) for any reason, such as during the treatment of Paget's Disease, Osteoporosis, Osteogenesis Imperfecta, Multiple Myeloma, or Metastatic Bone Disease from Breast or Prostrate Cancer?

❑ ❑ Have you taken Cocaine, Ecstasy or Methamphetamine within the last 24 hours?

❑ ❑ Are you allergic to any medicine of drugs such as Local Anaesthetic given by a dentist, Penicillin, Codeine, or Aspirin? If so, list: _____

❑ ❑ Are you allergic to latex or rubber?

❑ ❑ Do you have any other allergies? If so, list:_____

❑ ❑ Do you smoke or chew tobacco products? If so how often? _____

❑ ❑ *Women Only* - Are you nursing (breastfeeding) of pregnant? If pregnant, how many months: _____

Do you have or have you ever had any of the following: (please check yes or no box below):

Yes	No		Yes	No		Yes	No	
❑	❑	Chest Pain (angina pectoris)	❑	❑	Anemia	❑	❑	Arthritis
❑	❑	Heart Attack	❑	❑	High Blood Pressure	❑	❑	Stomach Ulcers
❑	❑	Pacemaker	❑	❑	Bleeding Problems/Disorder	❑	❑	Sinus Trouble
❑	❑	Infective Endocarditis	❑	❑	Stroke	❑	❑	Asthma
❑	❑	Congenital Heart Disease	❑	❑	Seizures/Epilepsy	❑	❑	Tuberculosis
❑	❑	Heart Transplant	❑	❑	Thyroid Disease	❑	❑	Glaucoma
❑	❑	Prosthetic/ Artificial Joint	❑	❑	Kidney Trouble	❑	❑	Steroid Therapy
❑	❑	Cancer	❑	❑	Diabetes	❑	❑	Hepatitis
❑	❑	Prosthetic. Artificial Heart Valves	❑	❑	Drug/Alcohol dependency	❑	❑	HIV or AIDS
❑	❑	Radiation Therapy to Head/Neck						

❑ ❑ Do you have any other serious illness? If so, explain: _____

Name of your physician (family doctor): _____ Phone: _____

When was the last time you saw a dentist? _____

Insurance Company:_____ Secondary Insurance Company:_____

Employer:_____ Secondary Employer:_____

Policy/Group #:_____ Secondary Policy/Group #:_____

ID/Certificate #:_____ Secondary ID/Certificate #:_____

Policy Holder's DOB (Y/M/D):_____ Secondary Policy Holder's DOB (Y/M/D):_____

Policy Holder's Name:_____ Secondary Policy Holder's Name:_____

The above medical history is complete and accurate. Consent for treatment is hereby given.

_____ _____

Signature of Patient / Parent / Guardian **Date**