

Patient Medical Form

Family Name:

First Name:

Date of Birth:

Home Phone:

Gender:

Cell Phone:

Home Address:

City:

Postal Code:

Work Phone:

Email:

Preferred method of contact to confirm appointments:

Home #

Cell#

Work#

Email

Text

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 checkup.

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

Have you been treated for any medical conditions within the last year? if so, list:

Have you taken any medicine, pills, or drugs withing 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 medical conditions that could affect your immune system, such as Lukemia?

Have you ever taken a Bisphosphonate medication such as Actonel (Risedronate), Aredia(Pamidronate), Bonfos(Clodronate), Bonva(Ibandronate), Didronal(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 Prostate 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? Such as 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) or pregnant? If pregnant, how many months?

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

Yes No

Chest Pain (angina pectoris)
Heart Attack
Pacemaker
Infective Endocarditis
Congenital Heart Disease
Heart Transplant
Prosthetic/Artificial Joint
Cancer
Prosthetic Artificial Heart Valves
Radiation Therapy to Head/Neck
Anemia
High Blood Pressure
Bleeding Problems/Disorder
Stroke

Yes No

Seizures/Epilepsy
Thyroid Disease
Kidney Trouble
Diabetes
Drug/Alcohol Dependency
Arthritis
Stomach Ulcers
Sinus Trouble
Asthma
Tuberculosis
Glaucoma
Steroid Therapy
Hepatitis
HIV or AIDS

Name of your physician (family doctor):

Phone:

When was the last time you saw a dentist?

Insurance Company:

Employer:

Policy/Group#:

ID/Certificate#:

Policy Holder's DOB:

Policy Holder's Name:

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

Signature of Patient/Parent/Guardian

Date