Patient Medical Form

Family Name: Fallahi First Name:

Date of Birth: Home Phone:

Gender: Select one: 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 medicne, 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 conditions or therapies that could affect your immune system, such as Lukemia?
○	○	Have you ever taken a Bisphosphonate medicarion such as Actonel (Risedronate), Aredia(Pamidronate), Benefos(Clodronate), Boniva(Ibandronate), Didronal(Etidronate), Fosamax(Alendronate), or Zometa(Zoledronic Acid) for any reason, such as during the treatment of Paget's Disease, Osteoporosis, Osterogenesis Imperfectca, 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? Choose one:

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

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