



PATIENT FORMS

PATIENT NAME: _____

1. Have you been under the care of a medical doctor during the last two years? YES NO

If yes, for what? _____

Physician's Name: _____ Phone: _____

2. Are you taking any medications or drugs now? YES NO

If yes, please list names and dosages _____

3. Are you aware of having an allergic/adverse reaction to any medication or substance? ... YES NO

If yes, please list _____

4. Have you been a patient in a hospital during the last five years? YES NO

If yes, for what? _____

5. Please indicate which of the following you have or have had and provide a brief explanation.

Heart / Cardiovascular Concerns YES NO Ulcers YES NO

Diabetes YES NO Thyroid Problems YES NO

Glaucoma YES NO Emphysema / COPD YES NO

Tuberculosis YES NO Asthma..... YES NO

Rheumatic Fever YES NO Latex Sensitivity..... YES NO

Arthritis / Rheumatism YES NO Sinus Troubles YES NO

Artificial Joints YES NO Radiation Therapy YES NO

Kidney Trouble YES NO Chemotherapy YES NO

Hepatitis YES NO HIV Positive / AIDS YES NO

Cold Sores / Fever Blisters YES NO Bleeding Concerns YES NO

Cancer / Cancer Treatment YES NO Neurological Disorder YES NO

6. WOMEN: Are you pregnant?..... YES NO Nursing? YES NO

Taking birth control pills? YES NO

7. Are or have you taken drugs such as Zometa, Aredia, Actenol, Boniva, or Fosamax? YES NO

8. Do you use tobacco products?..... YES NO

If yes, what product do you use and for how long? _____

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my ability. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor or his staff of any change in my health or medication.

PATIENT/GUARDIAN: _____ **DATE:** _____