

MEDICAL ALERT:

NAME:

PLEASE CIRCLE: MR. / MRS. / MS. / DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE

CELL #:

HOME #:

WORK #:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

E-MAIL :

Insurance Details

PRIMARY INSURANCE

INSURANCE CARRIER: _____

POLICY HOLDER: _____

DATE OF BIRTH: _____

POLICY (PLAN #): _____

CERTIFICATE (I.D. #): _____

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE CARRIER: _____

POLICY HOLDER: _____

DATE OF BIRTH: _____

POLICY (PLAN #): _____

CERTIFICATE (I.D. #): _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

(1) NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

(2) NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

The following information is required to enable us to provide you with the best possible dental care.

All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? Yes No Not Sure/Maybe

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain. Yes No Not Sure/Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them. Yes No Not Sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below: Yes No Not Sure/Maybe
a) medications _____
b) latex/rubber products _____
c) other (e.g. hay fever, seasonal/environmental, foods) _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. Yes No Not Sure/Maybe

7. Do you have or have you ever had asthma? Yes No Not Sure/Maybe

8. Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure/Maybe

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes No Not Sure/Maybe
10. Do you have a prosthetic or artificial joint? Yes No Not Sure/Maybe
11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? Yes No Not Sure/Maybe
12. Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure/Maybe
13. Do you have a bleeding problem or bleeding disorder? Yes No Not Sure/Maybe
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. Yes No Not Sure/Maybe

15. Do you have or have you ever had any of the following? Please check.

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> stroke, TIA | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> cancer | <input type="checkbox"/> arthritis | <input type="checkbox"/> drug/alcohol/cannabis use or dependency | <input type="checkbox"/> osteoporosis medications (e.g. Fosamax, Actonel) |

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain. Yes No Not Sure/Maybe

17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? Yes No Not Sure/Maybe

18. Do you smoke or chew tobacco products? Yes No Not Sure/Maybe

19. Are you nervous during dental treatment? Yes No Not Sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not Sure/Maybe

21. Do you identify as a patient with a disability? If yes, please explain. Yes No Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTIST'S NOTES: