Medical History

Office Use:
Name:_____
Allergy:_____
Med. Alert:_____
Premed:_____

Pregnancy

Are you pregnant?.....( )Yes ( ) No
Are you taking birth control pills? .....( )Yes ( ) No
Antibiotics can interfere with birth control pills by causing them not to work. Periodontal infections can increase the risk of low birth weights in newborns.

GENERAL QUESTIONS

Do you smoke?..... ( )Yes ( )No
How many packs per day?___For how many years?_____
Are you a nervous individual usually?..... ( )Yes ( )No
Do you grind, clench or snore?..... ( )Yes ( )No
Would you like an appliance to help prevent it?..... ( )Yes ( )No
Are you seeing a Counsellor or Psychiatrist?..... ( )Yes ( )No
Reason:_____
Do you get dizzy often or if you stand up too fast? ( )Yes ( )No

Breathing/Lungs

Do you have: Sinus Problems.....( )Yes ( )No
Seasonal Allergies.....( )Yes ( )No
Asthma..... ( )Yes ( )No
Do you use an inhaler or nebulizer?.....( )Yes ( )No
When was the last time you used it?_____

Diabetes

Do you have Diabetes?..... ( )Yes ( )No
( )Type 1 ( ) Type 2
Recent studies show a link between Periodontal Disease and Diabetes.

Bleeding

Do you have Anemia?.....( )Yes ( )No
Do you bleed easily?.....( )Yes ( )No
Why?_____
Are you on Coumadin, or other blood thinners?... . ( )Yes( )No
Do you have Hepatitis or Liver Disease?..... ( )Yes ( )No
If yes: ( )A ,( )B, ( )C, ( )D, ( ) Jaundice ( )Other_____

Allergies

Are you allergic to anything.....( )Yes ( )No
If Yes,What? ( )Penicillin ( )Codeine( )Anesthetic ( )Latex
Other:_____

Medications

Are you taking medications?..... ( )Yes ( )No
What medications are you taking?
( )Thyroid What? _____
( )Diabetes What? _____
( )Cholesterol What? _____
( )Osteoporosis What? _____
( )Blood Thinners What? _____
( )Blood Pressure What? _____
What other medications are you taking including "over the counter" i.e Aspirin, vitamins, etc.? **And Why**?
_____
_____
_____

Who Are Your Current Physicians?

Name:_____ Tel. #:_____
Treatment:_____
Name:_____ Tel. #:_____
Treatment:_____
Name:_____ Tel. #:_____
Treatment:_____
When was your last complete medical exam?
_____
Are you in good health? ..... ( )Yes ( )No

Cancer

Do you have cancer?..... ( )Yes ( )No
Have you ever had cancer?..... ( )Yes ( )No
When?_____
What kind?_____
How are you being treated?
( ) Surgery ( ) Chemotherapy ( ) Radiation

Nerves/Muscle/Bones

Do you have Seizures?..... ( )Yes ( )No
Do you have Joint Replacements?..... ( )Yes ( )No
What Type?_____
Do you have back problems?..... ( )Yes ( )No
Do you have a Neuromuscular Disorder?.....( )Yes( )No
What type?_____

Immune System

Do you have a history of an Immune Disorder such as Lupus, Organ Transplant, HIV, AIDS, ARC or other?
.....( )Yes ( )No
If yes, please explain:_____

Dental

When was your last dental cleaning?_____
When was your last dental procedure and for what type of treatment?_____
Have You ever had a Deep cleaning? When?_____

Heart Problems

Do you have abnormal blood pressure?.....( )Yes ( )No
Your normal blood pressure:_____/____. Is it High or Low?
Have you had a Stroke or Heart Attack?.....( )Yes ( )No
When?_____
Have you ever had a Pace Maker, Rheumatic Fever, Angina, Heart Valve Replaced, Heart Disease, Heart Murmur?.....( )Yes ( )No
If yes, what? _____
_____

Do you take antibiotics for dental appointments? ( )Yes ( )No
If Yes, What Type?_____

Anything else you feel we need to know about you?
_____
_____

_____ _____ _____ _____
Patient or Guardian Signature **Date** **Doctor Signature** **Date**

Welcome to

Member of the American Academy of Cosmetic Dentistry

Laser & Cosmetic
DENTISTRY OF DELRAY

Personal Information:

Todays Date:_____

Name:_____ Social Security:_____ Birth Date: _____
Address:_____ City/State/Zip: _____
Home Number: _____ Cell Number:_____ Work Number:_____ E-mail_____
Employer:_____ Occupation:_____
Address:_____City/State/Zip: _____
Married___ Single___ Divorced___ Widowed___ Spouse Name:_____ Employer:_____
EMERGENCY CONTACT: NAME_____ NUMBER:_____
Who may we thank for referring you to our office?_____

Insurance Information:

Insurance Company Name:_____ Policy Number_____
Name of covered employee:_____

Consent for Treatment & Authorization Release:

By state law we are required to make an attempt to inform patients of possible complications, even though rare, which could result from anesthesia, local and or sedation.
* Allergic reactions which could require hospitalization.
* Cardiac arrest, which could result in brain damage or even death.

*** It must be understood that these complications are extremely rare and every possible precaution will be taken to prevent their occurrence as well as to treat them successfully should they occur.**

The most common, even though rare, complications resulting from tooth extractions, periodontal therapy, cyst removal, biopsies, fillings, root canal therapy, crowns, veneers, bridges, etc, are:
* Bleeding heavy enough to stop therapy.
* Injury to adjacent teeth and fillings.
* Post-operative infection requiring additional treatment
* Possibility of a small piece of root being left in the jaw when its removal would require extensive surgery.
* Fracture or breakage of the jaw.
* Post-operative discomfort and swelling which may necessitate several days of home recuperation.
* Stretching of the corners of the mouth resulting in cracking and bruising.
* Recession of the gingiva (gums)
* Tooth mobility
* Tooth sensitivity, which may require additional treatment.
* Nerve injury, sensory and or motor, adjacent or on the side of the surgical site, especially underlying the teeth resulting in numbness of the palate, lips, tongue, chin, face, or other anatomical structures in the head and neck.

_____
Signature of Patient or Guardian