SPECIALISTS IN IMPLANT DENTISTRY

***Personal Information*:**

Name: _____ Date of Birth: _____
Emergency Contact Name: _____ Phone: _____
Address: _____ City:_____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work/Northern: _____
Email: _____ Referred By: _____

Current Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of Last Medical Exam: _____

Please check any conditions that apply to you now or in the past (*circle specific answers*):

ALLERGIES:
- ☐ Anesthesia (Local, IV, General)
- ☐ Hay Fever
- ☐ Latex
- ☐ Penicillin
- ☐ Other: _____

CANCER:
- ☐ Radiation to head/neck
- ☐ Chemotherapy
- ☐ If Yes, please explain what type of cancer and last date of treatment:

_____
_____
_____

HEART:
- ☐ AFIB/Arrhythmia/Pacemaker
- ☐ Artificial Heart Valve
- ☐ Aspirin Therapy
- ☐ Blood Thinner:_____
- ☐ Bypass/Stents Heart Attack/Heart
- ☐ Disease Heart Murmur/MVP
- ☐ High/Low Blood Pressure
- ☐ Heart Failure (CHF)

KIDNEYS/LIVER/STOMACH:
- ☐ Diabetes/Pre-Diabetic
- ☐ Dialysis/Kidney Transplant
- ☐ Jaundice/Liver Transplant
- ☐ Hepatitis: A B C
- ☐ Acid Reflux/GERD/IBS
- ☐ Celiac Disease/Ulcers
- ☐ Other: _____

LUNGS:
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Sleep Apnea/CPAP Machine
- ☐ Other: _____

NEUROLOGICAL:
- ☐ Anxiety/Depression
- ☐ Alzheimer's
- ☐ Dementia/Memory Loss
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia/Chronic Pain
- ☐ MS/Parkinson's
- ☐ Stroke/TIA
- ☐ Other: _____

ORTHOPEDIC:
- ☐ Arthritis
- ☐ Back/Neck Problems
- ☐ Hip Replacement/Pre-med?
- ☐ Knee Replacement/Pre-med?
- ☐ Other: _____
- ☐ Osteoporosis

Osteo Meds: Please check
- ☐ Actonel/Atelvia
- ☐ Boniva
- ☐ Fosomax
- ☐ Prolia/Xgeva
- ☐ Reclast/Zometa

How Long: _____
Last Dose: _____

OTHER:
- ☐ Alcoholism/Drug Abuse
- ☐ Autoimmune Disease (RA/Lupus)
- ☐ Cataracts/Glaucoma
- ☐ Cold Sores/Shingles
- ☐ HIV
- ☐ Thyroid/Parathyroid Disease
- ☐ Tobacco Use
- ☐ Currently pregnant: Yes/No

Please list **all** serious illness or surgeries past or present: _____

_____

Please list **all** medications you currently take: _____

_____

Are you currently under a physician's care: No / Yes (reason): _____

The above information is correct to the best of my knowledge, and I have received a copy of the office financial policy:

_____

Signature Date