DATE:

PLEASE MAKE ANY CHANGES BELOW

NAME:

ADDRESS:

Patient E-Mail:

Patient Cell Phone:

Patient Home Phone:

Patient Work Phone:

Patient Birthdate:

Do You Have Dental Insurance? YES NO

PLEASE PROVIDE THE FOLLOWING INFORMATION

1) Do you have or have ever had any heart disease?

If yes, explain:

2) Do you have a pacemaker?

If yes, please provide approximate date of placement:

3) Do you have high blood pressure or take a Blood Pressure and/or Blood Thinning Medication?

If yes, explain and/or list medication:

4) Have you ever had a stroke/TA?

If yes, explain:

5) Do you have or have you ever had bleeding problem or blood disorder?

If yes, explain:

6) Do you have or have you ever had any respiratory (breathing) disorders?

If yes, explain:

7) Do you have or have you ever had cancer?

If yes, explain:

8) Are you ALLERGIC to any antibiotics, medications, and/or dental anesthetics?

If yes, explain:

9) Do you use or have used tobacco products?

If yes, please list what type and daily amount consumed or list approximate quit date:

10) Are you, or have you ever been an alcoholic or addict?

If yes, explain:

11) Do you have or have you ever had any infectious diseases as an adult?

If yes, explain:

12) Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosomax or Zometa within the past twelve years?

If yes, please list medication(s) and duration of use:

13) Do you have any artifical joints?

If yes, what joint was replaced and when:

14) Are you Diabetic?

If yes, list type and any medication(s) you take for it:

15) Are you taking (or supposed to be taking) any other medicine, drugs or pills of any kind including over-the-counter, herbal and nutritional supplements?

If yes, list medication(s) and reason for taking them:

16) Do you have any other medical condition that you think we should know about?

If yes, explain:

FOR WOMEN ONLY

17) Are you pregnant or is there a possibiliy that you may be pregnant?

18) Are you breast feeding?

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Permission is granted for Country Club Dentistry to perform procedures necessary, including taking of photographs, radiographs (x-rays), conducting an examination and obtaining a medical consultation from my physician(s) in order to determine my dental treatment needs and clinical assignment. I also understand there is a minimal risk associated with exposure to dental radiation and that all appropriate precautions will be used to keep radiation exposure to a minimum. I understand that I have the right to refuse any procedure, but my refusal may result in termination of treatment.

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, abnormal laboratory test results, or if my medicines change, I will inform Country Club Dentistry at my next appointment.

Date

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