Dental/Medical History

Patient Name: ________________________________ **Date of Birth:** __________________

Dates: Last dental appt: _______________ **X-rays:**_____________ **Cleaning:** _______________

Name of former dentist: ________________________________ Phone #:____________________ Fax:______________________

Do you have a denture/partial denture? (Be specific) _______________________ If yes how old?_________

Reason for appointment: PLEASE EXPLAIN: ____

____

Primary Care Physician Name: ________________________________ **Phone**: _______________ Fax:______________________

Are you currently being treated by a physician? ____ If so, for what:____

Are you taking medications?____ If so, list or attach a complete list with dosage on separate page.____________________________

Do you require an antibiotic prior to dental appointment? _____ If so, why?____

Any recent hospitalizations? **List:** ____

Any allergies? _______________________________________ Please list reaction:_________________________________

Have you ever had a joint replacement? (Knees, hips, etc) ______________________________ **Date:** _________________________

Have you ever been diagnosed with oral cancer? ______ **Date:** _________ Heart valve replacement? ________ **Date:** ___________

History of bisphosphonates? (Oral or IV) _____ If yes, since when?____

Do you use a wheelchair? _____ Walker:_____ Can you transfer to a chair unassisted?______

Please enter any additional health concerns: ____

Please enter any additional information regarding the reason for needing a mobile visit: ______________________________________

Please put a X next to any of the following that apply and explain below:

AIDS/HIV_____ Anxiety/Nervous Disorder_____ Alzheimer_____ Depression_____ Diabetes_____ Chronic pain_____ COPD____

Respiratory Disease_____ Low Blood Pressure____ High Blood Pressure____ Congestive Heart Failure____ Respiratory Disease_____

Blindness____ Hearing Loss____ Seizures____ Sudden Weight Loss____ Parkinson____ Headache____ Oxygen use_____

Hepatitis_____ If yes, what kind______ Date diagnosed_______ Cancer_____ If so, what kind_____________ Date diagnosed_____

Autoimmune Disorder____ Other:____

I certify that above information about my medical history is accurate. I authorize and give consent for my dentist to perform dental services agreed upon as well as discuss dental care with my PCP.

X____ _______________

GUARDIAN/PATIENT/POWER OF ATTORNEY **SIGNATURE** **DATE**