CENTER FOR DENTAL EXCELLENCE

Excellence For Patient, Service And Community Since 1989

Patient Information

Name _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Email Address _____

Medical Information

Physician Name _____ Date of last physical exam _____

Address _____ City _____ State _____ Zip _____

Any serious illness, operations, or hospitalizations in the past year? ☐ Yes ☐ No If yes, please describe:

_____

_____

Please mark (X) to indicate if you have any of the following conditions:

- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Chest Pain
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Blood Transfusion
  If so, what date _____
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ Herpes Zoster
- ☐ Human Papilloma Virus
- ☐ Autoimmune Disease
  If so, what disorder(s):
  _____
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer/Chemotherapy/Radiation
  If so, please elaborate:
  _____
- ☐ Diabetes
  If so, Type I or II _____
  Last A1C Value _____
- ☐ High Cholesterol
- ☐ Gastrointestinal Disorder
- ☐ Acid Reflux
- ☐ Thyroid Problems
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Glaucoma
- ☐ Hepatitis
  If so, what type: _____
- ☐ Epilepsy
- ☐ Seizures
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Rheumatic Fever
- ☐ Chronic Pain
- ☐ Smoking/vaping
- ☐ Smokeless tobacco
- ☐ Recreational drug use
- ☐ Sleep apnea
- ☐ **No known medical issues**

Continued on back →

Please elaborate on any conditions previously noted:

Medications currently being taken, and for what reason:

Please list any allergies to any foods or medications (Or write "None" if you have no known allergies)

Are you currently pregnant and/or nursing? ☐ Yes ☐ No

History of Sleep Apnea? ☐ Yes ☐ No

Tonsils or Adenoid removed? ☐ Yes ☐ No

Has a physician or dentist recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

If yes, what antibiotic and for what reason? _____

Any history of joint replacements? ☐ Yes ☐ No If yes, what joint and what year was the surgery?

Any history of osteoporosis medications, such as Prolia, Fosamax, Boniva, or Reclast? ☐ Yes ☐ No

If yes, was it a pill or IV infusion? _____ Date of last treatment _____

Any anticoagulants that are currently being taken, such as Aspirin, Plavix, Xarelto, Eliquis, or Pradaxa?

☐ Yes ☐ No If yes, please describe: _____

Any hospitalizations or operations in the last 5 years? ☐ Yes ☐ No If yes, please describe: _____

Do you have any disease or condition not mentioned above? If yes, please describe: _____

Patient/Guardian _____ Date_____

Doctor Signature _____ Date_____