Dentaluxe

Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Address _____ Phone # (_____) _____
Are you under a physician's care now? □ Yes □ No If so, for what? _____

_____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? □ Yes □ No Please list below

_____

_____

Are you pregnant? □ Yes □ No If yes, due date _____

Do you use tobacco in any form? □ Yes □ No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? □ Yes □ No

Are you allergic to any medications or substances? □ Yes □ No If yes, please check boxes below.
□ Aspirin □ Penicillin □ Sulfa Drugs □ Codeine
□ Latex or Rubber □ Other

Have you ever had a reaction or experienced complications to any dental treatment in the past? □ Yes □ No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes		Yes		Yes	
□	Heart Trouble/Disease	□	Lung or Breathing Problems	□	Severe Headaches
□	Heart Murmur*	□	Shortness of Breath	□	Fainting or Dizzy Spells
□	Irregular Heart Beat	□	Sinus Trouble	□	Epilepsy, Seizures or Convulsions
□	Angina or Chest Pain	□	Asthma	□	Psychiatric Care
□	Heart Attack or Failure	□	Chronic Cough	□	Hepatitis, Jaundice or Liver disease
□	Congenital Heart Disorder	□	Emphysema	□	Arthritis, Gout or Rheumatism
□	Mitral Valve Prolapse*	□	Tuberculosis (TB)	□	Artificial Joint*
□	Rheumatic Fever*	□	Frequent Sore Throat	□	Night Sweats
□	Artificial Heart Valve*	□	Tumor or Cancer	□	Stomach or Intestinal Disease
□	Heart Pacemaker*	□	X-ray or Cobalt Treatment	□	Thyroid Disease
□	Heart Surgery	□	Chemotherapy	□	Kidney or Bladder Problems
□	Stroke	□	Enlarged Lymph Nodes (Glands)	□	Renal Dialysis
□	Aneurysm	□	Swelling of Limbs	□	Hypoglycemia
□	High Blood Pressure	□	Bruise Easily	□	Frequent Diarrhea
□	Low Blood Pressure	□	HIV Positive or AIDS	□	Glaucoma or Eye Problems
□	Bleeding Disorder	□	Sexually Transmitted Diseases	□	Excessive Thirst
□	Blood Transfusion	□	Major surgery	□	Diabetes

_____

Have you ever had any other disease, problem or condition not listed above? □ Yes □ No Discuss _____

_____

Do you wish to speak privately to the dentist about any problems? □ Yes □ No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.
Patient, Parent or Guardian Signature _____ Date _____