POINT PLACE DENTAL
we love to see you smile

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Name (Last, First, MI): _____
Date of Birth: _____
Today's Date: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you had a serious illness, operations or been hospitalized in the past 5 years?.....Yes ☐ No ☐

If yes, what was the illness or problem? _____

Do you smoke or use tobacco in any form? ..... Yes ☐ No ☐ Do you have difficulty hearing? .....Yes ☐ No ☐

Have you ever taken a bisphosphonate? (Fosamax, Boniva, Actonel, Zometa, Aredia)? ..... Yes ☐ No ☐

Do you require antibiotic prophylaxis medication prior to dental treatment? .....Yes ☐ No ☐

Are you taking any blood thinners? (Warfarin, Coumadin, Heparin, Plavix, Xarelto, Aspirin) .....Yes ☐ No ☐

Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....Yes ☐ No ☐

If yes, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

ALLERGIES (Please circle all that apply): Latex Penicillin Aspirin Codeine Local Anesthetics Metal None

Other: _____

FOR WOMEN:

Are you pregnant?..... Yes ☐ No ☐ Nursing?..... Yes ☐ No ☐ Taking birth control pills?..... Yes ☐ No ☐

PLEASE INDICATE IF YOU HAVE or HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

	Yes	No		Yes	No		Yes	No
Abnormal bleeding			Emphysema			Muscle or Joint Disorder		
Alcohol/drug abuse			Epilepsy			Pacemaker		
Anemia			Fainting Spells			Psychiatric Treatment		
Angina (Chest pains)			Frequent Headaches			Radiation Therapy		
Arthritis			Heart Attack/Surgery			Rheumatic/Scarlet Fever		
Artificial Joints/Valves			Heart Murmur			Seizures		
Asthma			Hepatitis			Sinus Problems		
Autoimmune Disease			Herpes/Fever Blisters			Sleep Apnea/Snoring/Sleep		
Bacterial Endocarditis			High/Low Blood Pressure			Stroke		
Blood Transfusion			High Cholesterol			Thyroid Problems		
Cancer/Chemotherapy			HIV/AIDs			Tuberculosis		
Chemical Dependency			Irregular Heartbeat			Ulcers/GERD		
Congenital Heart Defect			Kidney Problems			**OTHER (Please List):**		
Diabetes Type I or II			Liver Disease					
Difficulty Breathing			Mitral Valve Prolapse					

Have you had a joint replacement? Yes ☐ No ☐ **If yes, please indicate date and joint**:_____

Pharmacy Choice: _____

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment, with my informed consent.

Patient Signature Date

Provider Signature Date