PATIENT MEDICAL RECORD

mills river family DENTAL

NAME: _____
Date of Birth: ____/_____/_____
Married: YES NO
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: Hm: _____ Wk: _____
Cell: _____
Email Address: _____

EMERGENCY CONTACT:
Name: _____
Phone#: _____

DENTAL INSURANCE
Do you have dental insurance coverage? YES NO

DENTAL INFORMATION
What is your problem/concern at this time?
_____
_____

MEDICAL INFORMATION
Physician: _____
Phone #: _____

Are you under medical treatment now?
_____

Please list any **MEDICATIONS** currently taking:
_____
_____

Are you **ALLERGIC** to any medications/metals/latex?
_____
_____

Have you been hospitalized in the last 5 years? If so, why?
_____

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphonates?
YES NO
Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?
YES NO
Do you use tobacco?
YES NO
Do you use controlled substances?
YES NO
Do you have a persistent cough-more than 3 weeks?
YES NO
Women only: Pregnant? YES NO
Nursing? YES NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Epilepsy/Convulsions/Fainting	YES	NO
Leukemia	YES	NO
Diabetes	YES	NO
Kidney Disease	YES	NO
AIDS or HIV Infection	YES	NO
Sexually Transmitted Disease	YES	NO
Thyroid Problem	YES	NO
Anemia	YES	NO
Cancer	YES	NO
Radiation Therapy	YES	NO
Arthritis	YES	NO
Joint Replacement	YES	NO
Premedication	YES	NO
Hepatitis/Jaundice	YES	NO
Stomach Troubles/Ulcers	YES	NO
Hay Fever/Allergies	YES	NO
Tuberculosis	YES	NO
Glaucoma	YES	NO
Liver Disease	YES	NO
High Blood Pressure	YES	NO
Low Blood Pressure	YES	NO
Stroke	YES	NO
Heart Attack	YES	NO
Heart Disease/Murmur	YES	NO
Pacemaker	YES	NO
Angina (chest pains)	YES	NO
Emphysema	YES	NO
Asthma	YES	NO
Respiratory Problems	YES	NO

Is there anything else we should know about your health that we have not covered?
_____

RELEASE:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. If I am here on an emergency basis, I understand that this examination will address only my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment. I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

PATIENT'S or GUARDIAN'S SIGNATURE DATE

_____