ANAHEIM DENTAL Group
Implant & Cosmetic

Name: Birth Date:

MEDICAL INFORMATION

Yes No
☐ ☐ Are you currently under a physician's care?

____
Physician's Name

____
Phone Number

☐ ☐ Have you ever been hospitalized or had emergency room visit? Please explain:

____
____
____

☐ ☐ Are you taking any medications (including vitamins & herbal supplements)? Please list:

____
____
____

☐ ☐ Have you ever taken medications to treat osteoporosis such as Fosamax, Actonel, Aredia, Boniva or Zometa?

☐ ☐ Have you ev er taken Phen-Fen/Redux/Pondimin?

For women:
☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant or suspect you may be pregnant?
If yes, expected due date:________
☐ ☐ Are you nursing?

Do you have or had any of the following condition(s)?
☐ ☐ Alcohol/Drug Abuse
☐ ☐ Anemia
☐ ☐ Arthritis
☐ ☐ Aritifical Joints/Valves
☐ ☐ Asthma
☐ ☐ Bleeding Problems
☐ ☐ Blood Transfusion s
☐ ☐ Cancer/ Chemotheraphy
☐ ☐ Congenital Heart Defect s
☐ ☐ Diabetes
☐ ☐ Difficulty Breathing

Yes No
☐ ☐ Emphysema
☐ ☐ Epilepsy/ Sei zures
☐ ☐ Fainting/ Dizzy Spells
☐ ☐ Frequent Headache s
☐ ☐ Heart Attack/ Stroke
☐ ☐ Heart Murmur
☐ ☐ Heart Surgery
☐ ☐ Hepatitis
☐ ☐ Herpes/ Fever Blisters
☐ ☐ High Blood Pressure
☐ ☐ HIV Positive or AIDS
☐ ☐ Kidney Problems
☐ ☐ Liver Disease
☐ ☐ Mitral Valve Prolapse
☐ ☐ Pacemaker
☐ ☐ Prosthetic device/ Implant
☐ ☐ Psychiatric Problems
☐ ☐ Radiation Treatment
☐ ☐ Rheumatic Fever
☐ ☐ Sinus Problems
☐ ☐ Smoke/ Tobacco Use
☐ ☐ Thyroid Problems
☐ ☐ Tuberculosis
☐ ☐ Ulcers

Please list any other serious medical condition(s) that you have or had which are not listed above:

____
____
____

Are you **ALLERGIC** to any of the following?
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erthromycin
☐ ☐ Latex
☐ ☐ Metals
☐ ☐ Penicillin
☐ ☐ Sulfa drugs
☐ ☐ Tetracycline

Please list any other drugs/materials that you are allergic to:

____
____
____

DENTAL INFORMATION

Reason for your visit today:

____
____
____

Date of last dental visit:

____

Yes No
☐ ☐ Are you currently in pain?
☐ ☐ Do you require antibiotics before dental treatment?
☐ ☐ Have you ever had a serious problem associated with any previous dental work?

Have you ever been treated or have the following condition(s)?
☐ ☐ Bleeding Gums
☐ ☐ Clicking/Popping Jaw
☐ ☐ Chronic jaw pain/face pain
☐ ☐ Teeth Clenching/ Grinding
☐ ☐ Gum Treatment
☐ ☐ Loose T eeth
☐ ☐ Pain upon C hewing
☐ ☐ Recent Toothache/Sensitivity
☐ ☐ Would you be interested in whiter teeth?
☐ ☐ Are you happy with the way your smile looks?

I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquiries set forth about have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I have made in the completion of this form.

____
Patient (guardian) Signature Date

____
Dentist Signature Date