■ Medical History **■**

□□Abnormal Bleeding □□Difficulty Breathing □□Heart Disease □□Low Blood For Disease □□Reinting/Dizzy Spells □□Hemophilia □□Rheumatic For Disease □□Low Blood For Disease □□Low	Patient Name:	Date of I	Date of Birth:Tod	
List ALL MEDICATIONS currently taking (including supplements): Have you ever had any kind of surgery? □Yes □No If yes, When? For What? Do you have a Prosthetic Heart Valve or Joint Replacement/Pins (i.e. Hip, Knee, Ankle, etc)? □Yes □No Date: □Sescribe: Have you been told you need Pre-Medication prior to dental treatment? □Yes □No If yes, Why? Have you ever had any trouble with Prolonged Bleeding after surgery? □Yes □No Are You Taking Blood Thinners: □Baby Asprin □Asprin □Plavix □Coumadin □Pradaxa Other: Have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia etc)? □Yes □No Other: Do You Have Any Allergies: □Latex □Metals □Penicillin □Anesthetics Other: Women: Birth Control Medication □Yes □No □ Pregnant: # Weeks Are you Nursing? □Yes □No ■ CONDITIONS (check all that apply) ■ Y/N □NAnemia □□Diabetes □□Heart Attack □□Liver Diseas □□Anemia □□Diabetes □□Heart Attack □□Liver Disease □□Anemia □□Drug Addiction □□Heart Surgery □□Pacemaker □□Antritis □□Bimphysema □□Heart Surgery □□Pacemaker □□Antritis □□Bimphysema □□Hemophilia □□Rahematic F □□Antritis □□Bimphysema □□Hemophilia □□Rahematic F □□Autoimmune Disease □□Fever Blisters □□Hey □□Stroke □□Cancer □□Painting/Dizzy Spells □□High Blood Pressure □□Severe Head □□Autoimmune Disease □□Fever Blisters □□HPV □□Stroke □□Cancer □□GI Disease/Reflux □□Infective Endocarditis □□Thyroid Dise □□Congenital Heart Defect □□HIV+ AIDS Any other information we should know about your health?: ■ Dental History ■ Y/N Y/N Y/N □□ Sensitive Teeth □□ Jaw Pain (TMJ) □□ Bleeding Gums □□ Bad Breath □□ Discolored Teeth □□ Clenching/Grinding □□ Periodontal Disease □□ Tobacco Use □□ Dry Mouth □□ Cracked Teeth □□ Tooth Trauma Other Dental Conditions not mentioned above: I understand the information I have provided is correct to the best of my knowledge. I understand that	Physician's Name:	Physician's Phon	Physician's Phone:Date	
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□□Arthritis □□Emphysema □□Hemophilia □□Rheumatic F □□Asthma □□Epilepsy □□Hepatitis A, B or C □□Seizures □□Autism Spectrum Disorder □□Fainting/Dizzy Spells □□High Blood Pressure □□Severe Head □□Autoimmune Disease □□Fever Blisters □□HPV □□Stroke □□Cancer □□GI Disease/Reflux □□Infective Endocarditis □□Thyroid Disease/Reflux □□Congestive Heart Failure □□Herpes □□Kidney Problems □□Congenital Heart Defect □□HIV+ AIDS Any other information we should know about your health?: □□Dental History ■ Y/N Y/N Y/N Y/N Y/N □□ Sensitive Teeth □□ Jaw Pain (TMJ) □□ Bleeding Gums □□ Bad Breath □□Discolored Teeth □□ Clenching/Grinding □□ Periodontal Disease □□ Tobacco Use □□Dry Mouth □□ Cracked Teeth □□ Tooth Trauma Other Dental Conditions not mentioned above: □□Inderstand the information I have provided is correct to the best of my knowledge. I understand that it is the state of the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand that it is the provided is correct to the best of my knowledge. I understand the information I have provided is correct to the best of my knowledge. I understand the information I ha	□□Abnormal Bleeding	□□Difficulty Breathing	□□Heart Disease	□□Low Blood Pressure
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Y/N	Any other information we should	know about your health?:		
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Other Dental Conditions not mentioned above: I understand the information I have provided is correct to the best of my knowledge. I understand that				□□ Tobacco Use
I understand the information I have provided is correct to the best of my knowledge. I understand that	LL Dry Mouth	LL Cracked Teetn	LL Tooth Trauma	
	Other Dental Conditions not m	entioned above:		
information will be held in the strictest confidence and it is my responsibility to inform this office of any ci in my medical status.		the strictest confidence and it i	is my responsibility to inform	
Signature: Date:	Signature:	•		