North Central Family Dentistry

Matthew Lonier DDS

PATIENT'S NAME ____ **Today's Date** ______/_______/______

PATIENT MEDICAL HISTORY Are you under medical treatment now? **No** **Yes**...explain briefly
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____
____

EMERGENCY CONTACT: Whom may we contact in case of an emergency?
Name ____ Relation __________________________
Home Phone ________________________________ Work Phone _____________________________

Do you have OR have you had any of the following:								
Abnormal bleeding	Y	N	Freq. indigestion (GERD)	Y	N	Mitral valve prolapse	Y	N
Alcohol/drug abuse	Y	N	Glaucoma	Y	N	Pacemaker	Y	N
Anemia	Y	N	Heart attack	Y	N	Psychiatric problems	Y	N
Artificial joints/valves	Y	N	Heart murmur	Y	N	Radiation treatment	Y	N
Asthma	Y	N	Heart surgery	Y	N	Rheumatic/Scarlet fever	Y	N
Blood disorder	Y	N	Hepatitis A, B or C	Y	N	Seizures	Y	N
Cancer/Chemotherapy	Y	N	Herpes/Fever blisters	Y	N	Sickle cell disease	Y	N
Colitis	Y	N	High blood pressure	Y	N	Sinus problems	Y	N
Congenital heart defect	Y	N	HIV+/AIDS	Y	N	Stents	Y	N
Diabetes	Y	N	Kidney disease	Y	N	Stroke	Y	N
Emphysema	Y	N	Liver disease	Y	N	Thyroid problems	Y	N
Epilepsy	Y	N	Low blood pressure	Y	N	Tuberculosis (TB)	Y	N
Fainting spells	Y	N	Lupus	Y	N			
Women only: Pregnant/May be pregnant **Y N** Nursing **Y N** Oral Contraceptives **Y N**								

MEDICATIONS: Please list any prescription and non-prescription meds you are taking at this time.
____
____
____

Do you regularly take antibiotics prior to dental work? **N** **Y**...please list reason and medication name:
____
Are you currently taking any blood-thinning meds? **N** **Y**...name: ______________________________
Are you currently taking/have you ever taken weight-loss meds such as Fen-Phen/Redux? **N** **Y**
Are you currently taking/have you ever taken bisphosphonate meds such as Actonel/Fosamax/Zometa? **N** **Y**

ALLERGIES: Have you ever had any allergic or adverse reactions to the following:
Anesthetics (Lidocaine) **Y N** Codeine **Y N** Penicillin **Y N** Sulfa drugs **Y N**
Latex Rubber **Y N** Aspirin **Y N** Other antibiotics **Y N** Jewelry/Metals **Y N**
Other allergies, please list: ____

Do you smoke or use chewing tobacco? **N** **Y**...how much/how long? ______________________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. These questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize and request my insurance company pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

___________________________________ ________________

Signature of patient (or parent/guardian) **Date**