MEDICAL HISTORY

SAVING SMILES DENTISTRY
www.savingsmilesdentistry.com

Patient Name: _____

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

Medications:

_____

_____

_____

Do you take blood thinners? ☐ Yes ☐ No

Have you ever been told to take antibiotics before dental treatment? ☐ Yes ☐ No

Do you have any drug allergies or have you ever had an adverse reaction to medication?

☐ Yes ☐ No If yes, what? _____

Have you had any surgeries in the last 24 months? ☐ Yes ☐ No

If yes, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Have you ever had the following? (Check all that apply)

☐ Heart Problems	☐ Liver Problems	☐ Sinus Problems
☐ Circulation Problems	☐ Epilepsy	☐ Breathing Problems
☐ Pacemaker	☐ Osteoporosis	☐ Chemical Dependency
☐ High Blood Pressure	☐ Back Problems	☐ Tobacco Use
☐ Parkinson's Disease	☐ Artificial Joints	☐ Eating Disorder
☐ Diabetes	☐ Hepatitis	☐ Psychiatric Care
☐ Stroke	☐ AIDS	☐ Anxiety Disorder
☐ Radiation Treatment	☐ Cancer (site) _____	

Females: Are you pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Use Birth Control? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold Saving Smiles Dentistry responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____