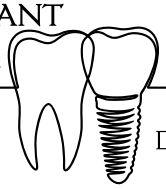
Dental Health History Update

Akhrass Dental Implant & Cosmetic Center



DDS
FAAID
DABOI/ID

Name: _____
(Last) (First) (Middle Initial)

Home Number: _____ Work Number: _____ Cell Phone: _____

Soc. Security #:_____ Birthdate:_____ Sex: M _____ F_____

Marital Status (Circle One): Single Married Widowed Divorced

Address: _____ City:_____State:_____ Zip:_____

Email:_____

Confirm my appointments by (Circle One): Text Message Email Phone Call

Dental Insurance:_____ **Subscriber Name:**_____**Sub Birthdate:**_____

Ins Subscriber #:_____ **Group #:**_____

Medical History

Reason for today's visit:_____

Name of family doctor:_____Date of last visit:_____

Have you had any serious illnesses or operations? Y / N If yes, describe:_____

Have you ever been told by your physician that you must take an antibiotic prior to dental procedures due to a recent joint replacement, heart surgery, etc. Y / N

Have you ever had a blood transfusion? Y / N If yes, give approximate date:_____

(Women) Are you pregnant? Y / N Nursing? Y / N Taking birth control pills? Y / N

MEDICATIONS

List any and all medications you are taking:

_____

_____

_____

ALLERGIES:

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ LATEX
- ❑ Other

_____

Medical History

Check if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatment
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Skin Rash
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems

Describe _____

- ❑ Hemophilia/Excessive Bleeding
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Artificial Heart Valves
- ❑ Migraines
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Therapy
- ❑ Respiratory Disease
- ❑ Sleep Apnea
- ❑ Rheumatic Fever
- ❑ ADD/ADHD
- ❑ Seizures
- ❑ Reflux
- ❑ Stroke
- ❑ Swelling Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

List and Supplements you are taking, i.e. garlic, vitamins, etc._____

_____

The above information is complete and accurate to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____ DATE: _____