AspenDental®
Let us help you find your smile.

Health Information

ASPEN DENTAL TAKES YOUR ORAL HEALTH VERY SERIOUSLY. BUT BEFORE WE START YOUR TREATMENT, WE NEED SOME BRIEF INFORMATION ON YOUR MEDICAL HISTORY. YOUR MEDICAL HISTORY MAY AFFECT DENTAL TREATMENT. **ALL INFORMATION IS CONFIDENTIAL.**

Patient's Name: _____ Date of Birth: _____ Last Physical Date: _____

Acct. #_____ Physician's Name & Phone #: _____

Reason for today's visit?_____

Work Related Injury? (circle) **Yes** **No** Have you been under the care of a physician? (circle) **Yes** **No**

Date of last dental visit: _____Have you ever been hospitalized? (circle) **Yes** **No**

Date of last dental x-rays:_____ Ever had Novocaine or other local anesthetic? (circle) **Yes** **No**

If wearing dentures, age of dentures:_____

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes** **No**

Are you taking or have taken Oral Bisphosphonates, e.g., **FOSAMAX, ACTONEL, BONIVA,** or IV Bisphosphonates, e.g., **ZOMETA, AREDIA?** (circle) **Yes** **No** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes** **No**

List any medications you are allergic to:

1. _____ 2. _____ 3._____4. _____

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1. _____ 2. _____ 3._____4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Asprin/Anticoagulant Therapy			Ulcers or Stomach Problems			Teeth Grinding/Clenching		
Pace Maker/Heart Surgery			Venereal Disease			Arthritis			Pain in your jaw (TMJ)		
High Blood Pressure			HIV Positive/Aids			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any type of Transplant		
Heart Problem ( )			Excessive Bleeding			Cancer (Type:)			Any Artificial Hip, Knee or other Joint		
Stroke			Hepatitis (Type:)			Chemotherapy			Other Disease or Illness:		
Lung Disease			Liver Disease			Radiation Treatment					
Breathing Problems			Kidney Disease			Use of Tobacco Products					
Tuberculosis (TB)			Dialysis			Drug Addiction					

Women	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		
NOTE: **Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.**					

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature _____ Date _____ Dr's. Signature/Medical History Review _____ Date _____

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OFFICE USE ONLY

DATE _____

PATIENT SIGNATURE _____

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