誠 Zen
DENTAL GROUP

Name: Birth Date:

# MEDICAL INFORMATION

**Yes No**

□ □ Are you currently under a physician's care?

Physician's Name

Phone Number

□ □ Have you ever been hospitalized or had emergency room visit? Please explain:

□ □ Are you taking any medications (including vitamins & herbal supplements)? Please list:

□ □ Have you ever taken medications to treat osteoporosis such as Fosamax, Actonel, Aredia, Boniva or Zometa?

□ □ Have you ever taken Phen-Fen/Redux/Pondimin?

Do you have or had any of the following condition(s)?

□ □ Alcohol/Drug Abuse
□ □ Anemia
□ □ Arthritis
□ □ Aritifical Joints/Valves
□ □ Asthma
□ □ Bleeding Problems
□ □ Blood Transfusions
□ □ Cancer/ Chemotheraphy
□ □ Congenital Heart Defects
□ □ Diabetes
□ □ Difficulty Breathing
□ □ Emphysema
□ □ Epilepsy/ Seizures
□ □ Fainting/ Dizzy Spells
□ □ Frequent Headaches
□ □ Heart Attack/ Stroke
□ □ Heart Murmur
□ □ Heart Surgery
□ □ Hepatitis

**Yes No**

□ □ Herpes/ Fever Blisters
□ □ High Blood Pressure
□ □ HIV Positive or AIDS
□ □ Kidney Problems
□ □ Liver Disease
□ □ Mitral Valve Prolapse
□ □ Pacemaker
□ □ Prosthetic device/ Implant
□ □ Psychiatric Problems
□ □ Radiation Treatment
□ □ Rheumatic Fever
□ □ Sinus Problems
□ □ Smoke/ Tobacco Use
□ □ Thyroid Problems
□ □ Tuberculosis
□ □ Ulcers

Please list any other serious medical condition(s) that you have or had which are not listed above:

Are you **ALLERGIC** to any of the following?

□ □ Aspirin
□ □ Codeine
□ □ Dental Anesthetics
□ □ Erthromycin
□ □ Latex
□ □ Metals
□ □ Penicillin
□ □ Sulfa drugs
□ □ Tetracycline

Please list any other drugs/materials that you are allergic to:

**FOR WOMEN ONLY:**

□ □ Are you taking birth control pills?

□ □ Are you pregnant or suspect you may be pregnant?
If yes, expected due date:_____

□ □ Are you nursing?

# DENTAL INFORMATION

Reason for your visit today:

Date of last dental visit:

**Yes No**

□ □ Are you currently in pain?
□ □ Do you require antibiotics before dental treatment?
□ □ Have you ever had a serious problem associated with any previous dental work?

Have you ever been treated or have the following condition(s)?

□ □ Bleeding Gums
□ □ Clicking/Popping Jaw
□ □ Chronic jaw pain/face pain
□ □ Teeth Clenching/ Grinding
□ □ Gum Treatment
□ □ Loose Teeth
□ □ Pain upon Chewing
□ □ Recent Toothache/Sensitivity
□ □ Would you be interested in whiter teeth?
□ □ Are you happy with the way your smile looks?

I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquiries set forth about have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omission that I have made in the completion of this form.

Patient (guardian) Signature Date

Dentist Signature Date