Dental Implants
Cynthia Gomez, D.D.S.

CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

NAME (Last,Middle,First)____ Title:____________
ADDRESS:____
PREFERRED NAME:__________________________S.S.NO: __________________ DOB:______________
HOME PHONE:________________ CELL PHONE:_________________ WORK PHONE:_______________
SEX:_________ MARITAL STATUS:_______________ EMAIL:______________________________
EMPLOYER:__________________________PERSON RESPONSIBLE FOR ACCOUNT:_________________
INSURANCE COMPANY:______________________________ GROUP NUMBER:____________________
EMERGENCY CONTACT:_________________________ PHYSICIAN"S NAME:_____________________
WHOM MAY WE THANK FOR REFERRING YOU?_________________________________

DATE OF LAST PHYSICAL EXAM:________________________
ARE YOU NOW UNDER A PHYSICIAN"S CARE?______Yes_______No
REASON:____
HAVE YOU EVER BEEN A PATIENT IN A HOSPITAL OR HAD A SERIOUS ILLNESS? _____________________
EXPLAIN:____

CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED:

Yes	No		Yes	No		Yes	No	
__	__	arthritis	__	__	hepatitis or jaundice	__	__	prolonged bleeding
__	__	rheumatic fever	__	__	liver disease	__	__	fainting tendency
__	__	heart trouble	__	__	cancer or tumor	__	__	epilepsy
__	__	heart murmur	__	__	tuberculosis	__	__	thyroid disease
__	__	high/low blood pressure	__	__	diabetes	__	__	glaucoma
__	__	chest pain	__	__	kidney/bladder problem	__	__	radiation treatment
__	__	stroke	__	__	anemia	__	__	mental disorder
__	__	shortness of breath	__	__	lung disease	__	__	HIV or AIDS
__	__	asthma or hayfever	__	__	venereal disease	__	__	prosthetic joint
__	__	sinus trouble	__	__	blood disease	__	__	blood transfusion
__	__	chemical dependency	__	__	chronic diarrhea	__	__	pacemaker
__	__	psychiatric care	__	__	sinus problems	__	__	osteoporosis

CHECK ANY OF THE FOLLOWING THAT ARE TAKING OR HAVE TAKEN:

Yes	No		Yes	No		Yes	No	
__	__	cortisone drugs	__	__	anticoagulants	__	__	tranquilizers
__	__	steroids	__	__	blood thinners	__	__	sedatives

ARE YOU TAKING ANY OTHER MEDICATION? IF YES,

PLEASE LIST ALL MEDICATION-INCLUDING VITAMINS AND HERBAL SUPPLEMENTS:

____
____

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DENTAL IMPLANTS IN THE CITY

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FOR WOMEN ONLY:

ARE YOU PREGNANT?_________ IF YES, HOW MANY MONTHS?____________BREAST FEEDING?________

ARE YOU PRESENTLY TAKING MEDICINE OF ANY KIND ROUTINELY?(BIRTH CONTROL PILLS,HRT,BONE DENSITY MEDICATION)______________EXPLAIN:____

____

DENTAL HISTORY:

DO YOU HAVE ANY ALLERGY,OR HAVE YOU EVER HAD AN ADVERSE REACTION TO ANESTHESIA? _______

IF SO, WHAT? ____

HAVE YOU EVER RESPONDED ADVERSELY TO DENTAL TREATMENT?________________________________

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL/DENTAL HISTORY?______________

____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this kind of form. I understand that it is my responsibility to inform the doctor if I,or my minor child, ever have a change in health.

NAME AND ADDRESS:____

Signature:____

Date:__________________________

MEDICAL HISTORY UPDATE:

HAS THERE BEEN ANY CHANGE IN THE PATIENT'S HEALTH SINCE THE LAST APPOINTMENT?___________

PLEASE LIST NEW MEDICATION____

PATIENT SIGNATURE______________________________________ DATE______________________________

MEDICAL HISTORY UPDATE:

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PLEASE LIST NEW MEDICATION____

PATIENT SIGNATURE______________________________________ DATE______________________________

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HAS THERE BEEN ANY CHANGE IN THE PATIENT'S HEALTH SINCE THE LAST APPOINTMENT?___________

PLEASE LIST NEW MEDICATION____

PATIENT SIGNATURE______________________________________ DATE______________________________

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