Holdbrook Pediatric Dental LLC

Adult Medical History 9/3/14 present

Patent Name: _____ Birth Date: _____Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your dental treatment. In order for us to treat you safety, please answer all questions accurately. Thank you.

Last Dental Visit/Cleaning/Xray?	[ ]		If yes _____
What is your main dental concern?	[ ]		If yes _____
If you're anxious, how can we help?	☐ Yes	☐ No	If yes _____
Have you had braces?	☐ Yes	☐ No	If yes _____
Have you had periodontal (gum) treatment?	☐ Yes	☐ No	If yes _____
Have you had your wisdom teeth removed?	☐ Yes	☐ No	If yes _____
Are you required to take Antibiotic Pre-Medication prior to dental treatment?	☐ Yes	☐ No	If yes _____

Medical Doctor's (Name/Number)

Previous Dentist

Pharmacy's (Name/Number)

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

If pregnant please provide Due Date and OBGYN ☐ If yes _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other - Please List

Addicted to or recovering from Drugs or Alcohol? ☐ Yes ☐ No

Use any Tobacco products? (How much/ How Long) ☐ Yes ☐ No

Do you have a history of any of the following?

High Blood Pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Emphysema/COPD	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Venereal Diseases	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Artifical Heart Valve	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Liver Disease/Cirrohsis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Osteogenesis Imperfecta	☐ Yes	☐ No	Artritis/Gout	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Bone Cancer/Disease	☐ Yes	☐ No	Alzheimer's Disease	☐ Yes	☐ No
Blood Transfusions	☐ Yes	☐ No	Paget's Syndrome	☐ Yes	☐ No	Psychiatric Disorder	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Myeloma	☐ Yes	☐ No	Developmental Delay	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No	Mentally Disabled	☐ Yes	☐ No
Swollen Limbs	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No	Epilepsy (seizures)	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Stomach Ulcers/Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Congenital Heart Defects	☐ Yes	☐ No	TM) Disorder	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Grinding of Teeth	☐ Yes	☐ No	Metal Rods/Pins	☐ Yes	☐ No
Diabetes I or II	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Head/Neck/Back Injury	☐ Yes	☐ No

Medical History Lists

Please List Any other Illnesses, Surgeries or Hospitilizations (Why/When) ☐ Yes ☐ No

Current Medication List ☐ Yes ☐ No

Have you ever used any Bisphosphonate meds such as: Fosomax, Aredia, Actonel, Zometa, Boniva etc? ☐ Yes ☐ No

Have you used any weight lose medications such as: Fen-Phen/Redux? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
I authorize the doctor and his team to take x-rays, study models and photographs. I authorize the doctor to perform any and all forms of treatment, use local anesthetic and any other medical therapy deemed necessary. I understand I am responsible for payments of dental services for myself and my dependants, payable at the time of service unless otherwise arranged. Holdbrook Pedicatric Dental accepts insurance assignments as a courtesy to me and I am responsible for any cost the insurance does not pay.
At Holdbrook Dental we are dedicated to staying on schedule for the benefit of our patients. We ask that you help us by keeping your appointments on time. We require 24 hours notice if you must cancel/change your appointment and all appointments should be confirmed.

Signature of Patient, Parent or Guardian:

X _____ **Date:** _____