Suncook Dental

Medical Information and History

Please complete this form for yourself or your dependant to the best of your ability. If you have any questions or concerns, please do not hesitate to ask. At Suncook Dental, we inquire about any changes in your health at each visit. We also update this form every two years.

First Name_____ **Last Name**_____ **Date of Birth**_____

Please Provide Your Current Phone #: Cell:_____ Home:_____ Work:_____

Medical Doctor_____ City _____ Approx. date last seen_____

Are you currently being treated for anything by a physician? **Yes No** If yes, for what?_____

Are you in good health? **Yes No** Do you heal normally? **Yes No**

Women Only - Do you take Birth Control Pills? **Yes No** Are you Pregnant? **Yes No** Are you Nursing? **Yes No**

Please list all allergies including allergies to medications_____

_____

Hospitalizations and dates: _____

_____

Medications you are taking and reason for taking: _____

_____

Do you have a history of or have you ever been treated for any of the following conditions?

1. Any Heart problems	Yes No	12. Dementia/Alzheimers	Yes No	23. Blood Disease	Yes No
2. Heart Attack	Yes No	13. Anemia	Yes No	24. Venereal Disease	Yes No
3. Heart Surger	Yes No	14. Artificial Joints	Yes No	25. HIV/ AIDS	Yes No
4. High Blood Pressure	Yes No	15. Arthritis	Yes No	26. Cancer or Tumors	Yes No
5. Pacemaker	Yes No	16. Asthma	Yes No	27. Mental Illness-Anxiety	Yes No
6. Artificial Valves	Yes No	17. Head Injury	Yes No	28. Sleep Disorder	Yes No
7. Mitral Valve Prolapse	Yes No	18. Respiratory Disease	Yes No	29. Do you bruise easily?	Yes No
8. Rheumatic Fever	Yes No	19. Kidney Disease	Yes No	30. History of smoking	Yes No
9. Stroke	Yes No	20. Liver Disease or Hepatitis	Yes No	31. Eating Disorder	Yes No
10. Epilepsy or Seizures	Yes No	21. Diabetes	Yes No		
11. Cold Sores/Oral Herpes	Yes No	22. Alcoholism	Yes No		

Please explain any "YES" answers _____

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Please provide any additional pertinent information here:_____

_____

Have you been told that you need to pre-medicate for dental treatment? Yes No

Are you taking any Bisphosphonates (medication for bone density)? Yes No

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I understand the above information is necessary to provide me or my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

In the event that I cannot accompany my minor child, I give my permission for the adult who accompanies him or her to act on my behalf. If my minor child comes unaccompanied, permission will be implied.

Patient or Parent (Guardian) Signature _____ Date _____

Reviewed by Staff: _____ Doctor: _____