DENTAL SURGEONS & IMPLANT CENTERS
OF FALL RIVER AND DARTMOUTH

Patient Name: _____Height_____Weight_____DOB ____/____/____ Age_____

Dentist_____Primary Physician_____PCP tel#_____ Last Visit_____/_____/_____

Pharmacy Name_____ Address_____ Tel#_____

HAVE YOU EVER HAD OR HAVE YOU NOW: (PLEASE CHECK AT THE RIGHT OF EACH ITEM)

Check Each Item (use Ink only)	Yes	No	Don't Know	Check Each Item (use Ink only)	Yes	No	Don't Know	Check Each Item (Use Ink only)	Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia				Ulcers/Reflux			
Fainting or Dizziness				Bruise/Bleed easily				Kidney Problems			
Nervousness				Heart problems/ Or Angina				Venereal Disease			
Stroke				Hypertension / High Blood pressure				Diabetes Type: _____			
Glaucoma				Rheumatic Fever				Thyroid Disease			
Cold Sores (Herpes)				Heart Murmur				Arthritis			
Persistent Cough				Mitral Valve Prolapse				Painful Joint(s)			
Emphysema				Congenital Heart Lesion				Prosthetic Joint(s)			
Tuberculosis/PPD Positive				Heart Surgery				Hives			
Asthma				Prosthetic Heart Valve(s)				Steroid Medication(s)			
Hay Fever				Pacemaker				Anxiety/Depression			
Sinus Problems				Blood Transfusion(s)				Alcoholism/Drug Addiction			
Anemia				Liver Disease				Significant Weight Gain/Loss			
Sickle cell disease				Hepatitis Type: _____				Cancer/ Radiation Treatment			
Chest Pain				Sleep Apnea				TMJ Problems			
Ankle Swelling				Difficulty with Anesthesia				Osteoporosis			
Birth Control Medication(s)				Pregnant _____YES _____NO Estimated Delivery_____							

Be aware that some medications can decrease the effectiveness of birth control medication(s)

1.Do you require Pre-Medication with Antibiotics prior to Dental Treatment for Rheumatic Fever, Heart Valve, Joint Replacement or Kidney Dialysis? _____YES _____NO

2a. Do you have any Disease, Condition or Problem no listed above? If yes, please describe:

2b. Are you under the care of a Physician? _____YES _____NO Reason?

3. Do you have any ALLERGIES? If yes, please list (Including medications or Latex)

4. Have you had any surgeries or hospitalizations? If yes, please list and date:

5. PLEASE LIST ANY MEDICATIONS & DOSAGES YOU TAKE ON A REGULAR BASIS (INCLUDING HERBAL SUPPLIMENTS OR ASPIRIN)

6. Do you smoke or chew tobacco? YES_____ NO_____ How many years?

7. Do you use Street Drugs (Including Marijuana)? YES_____ NO_____ How many years?

8. Do you use Alcohol? YES_____ NO_____ How frequently?

9. Is there anything you wish to discuss privately with the Doctor? YES_____ NO _____

I certify that I have read & understand the above. I will not hold my doctor or any member of his staff responsible for any errors or omission that I may have made in the completion of this form.

Please sign & date below: Patient (Parent or Guardian if Minor)	Any changes since last Visit? Please circle	Reviewing Doctors signature & Date:
X Date:	Yes No	Date:
X Date:	Yes No	Date: