

Previous Medical/Dental Information

MEDICAL	Physician Name _____	City/State _____
Date of Last Medical Visit _____ Reason _____		
DENTAL	Dentist Name _____	City/State _____
Date of Last Visit _____ Reason _____		
Date of Last Complete Series X-rays: _____		
Why did you leave your last dentist? _____		

Past /Present Medical History

Rheumatic Fever	Y N	Hepatitis	Y N	ALLERGIES:	
Heart Valve Replace	Y N	Aids/Immune Disease	Y N	Penicillin	Y N
Mitral Valve Prolapse		Convulsions	Y N	Erythromycin	Y N
MVP	Y N	Lung/Liver/Kidney Disease	Y N	Clindamycin	Y N
Pacemaker	Y N	Diabetes	Y N	Tetracycline	Y N
High Blood Pressure	Y N	Asthma or		Sulfa Drugs	Y N
Heart/Chest Pain	Y N	Bronchitis	Y N	Codeine	Y N
Bleeding Tendency	Y N	Anemia	Y N	Aspirin/Tylenol	Y N
Heart Attack/Stroke	Y N			Fruits or Flavors	Y N
Ever been chemically dependent?	Y N				

How did you find out about our office? _____

Are you currently pregnant or nursing?.....**Y N**

Do you need to PREMEDIATE with antibiotics before dental treatment?.....**Y N**

Do you smoke?.....**Y N** —▶ If yes how much?....._____/day

Do you get Herpes lesions (cold sores)?.....**Y N** If yes how often per year? _____

Are you being treated by a physician now?.....**Y N**

If yes for what condition? _____

List any medications you are now taking (list medication and reason for taking)

What kind of Dental Care are you seeking? _____

If you could avoid dental problems for the next ten or twenty years, would you like to have that dental treatment performed? _____

Do you like your smile?**Y N** What would you change if possible? _____

Are you aware of the health dangers of mercury? **Y N**

Are you aware of the dangers of fluoride? **Y N**

Are you concerned about the mercury fillings in your mouth? **Y N**

Would you like us to send a report of our dental findings to any healthcare provider? **Y N**

If yes to the above question, please provide us with that provider(s) name and address (below).

I consent to necessary treatment by Dr. Robbins, as it will be explained to me, along with possible side effects, in advance. I understand that regardless of my insurance coverage, I am financially responsible to Dr. Robbins for my account. I understand there may be a charge for appointments missed or cancelled by me without 48-hour advance notice, unless my allotted time can be appointed to another patient. I permit Dr. Donald Robbins, D.M.D. to release my records, as may be necessary to physicians, dentists, attorneys, other health care providers and insurance companies involved in my health care.

DATE: _____ SIGNATURE: _____

(AT NEXTCHECKUP) I have reviewed this form. There are no changes to my health at this time.

DATE: _____ SIGNATURE: _____

FOR DENTAL STAFF ONLY

I have reviewed this form with the patient and have initialed below

DATE/REVIEWER

_____	_____
_____	_____
_____	_____
_____	_____