

PREVIOUS MEDICAL/DENTAL INFORMATION

MEDICAL Physician Name _____ City/State _____
 Date Last Medical Visit _____ Reason _____

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

PAST MEDICAL HISTORY

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

List any *supplements* you are now taking (**please fill out on attached sheet**).

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 concerned about the Mercury Silver Fillings in your mouth?Y N

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

_____	_____
_____	_____
_____	_____