Bertram Dental

Please fill out this form as completely as possible. The better we communicate, the better we can care for you!

Name_____ I prefer to be called _____

DOB _____ SS# _____ Email Address _____

Address_____ City _____ State_____ Zip Code_____

Phone # _____ Cell # _____ Employer_____ Phone #_____

Emergency Contact:_____ Phone#_____ Relation_____

Physician_____ Date of Last Physical Exam _____Date of Last Dental Exam _____

How did you hear about us? _____

DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?

Breathing/respiratory problems	**Y**	**N**	Thyroid Issues	**Y**	**N**
Asthma	**Y**	**N**	Diabetes	**Y**	**N**
History of tuberculosis (TB)	**Y**	**N**	**Artificial Bones, Joints, Valves** (circle one)	**Y**	**N**
High / low blood pressure(circle one)	**Y**	**N**	Depression/Psychiatric Problems (circle one)	**Y**	**N**
Stroke	**Y**	**N**	Alcohol or Drug Abuse (circle one)	**Y**	**N**
Heart Attack or Angina	**Y**	**N**	Fibromyalgia	**Y**	**N**
Heart Surgery/Pacemaker(circle one)	**Y**	**N**	Sleep Apnea	**Y**	**N**
Congenital Heart Defect	**Y**	**N**	Cancer (If yes, what type?)	**Y**	**N**
Artificial Heart Valves	**Y**	**N**	Chemotherapy	**Y**	**N**
Coronary Artery Disease	**Y**	**N**	Radiation Therapy	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	**ALLERGIES TO ANY OF THE FOLLOWING**:		
Rheumatic Fever	**Y**	**N**	Latex	**Y**	**N**
Ulcer, GERD, Colitis (circle one)	**Y**	**N**	Penicillin	**Y**	**N**
Epilepsy/Seizures (circle one)	**Y**	**N**	Codeine, Aspirin, or other pain meds	**Y**	**N**
Liver Disease	**Y**	**N**	Dental Anesthetics	**Y**	**N**
Hepatitis A, B, or C (circle one)	**Y**	**N**	Other	**Y**	**N**
Kidney Disease	**Y**	**N**	If yes, please explain _____		
HIV positive	**Y**	**N**	**FEMALE PATIENTS ONLY**:		
Osteoporosis If yes, have you taken	**Y**	**N**	Pregnant or Nursing	**Y**	**N**
Bisphosphonates?_____			Using a prescribed method of birth control	**Y**	**N**

Have you ever had any serious medical conditions not listed on this form? _____

Have you been hospitalized in the past 5 years and for what? _____

Do you smoke or use tobacco of any form? _____ Are you interested in quitting? _____

Are you currently or have you ever taken blood thinners? Y N If yes, please list _____

Why have you come to the dentist today? _____Have you ever required antibiotics before dental treatment? _____

Please list each prescription drug you are taking: _____

_____

_____ _____
Signature Date

Review of Medical History

1. _____ 2. _____
Signature Date Signature Date

3._____ 4. _____
Signature Date Signature Date

For Office Use: ASA class_____ Mallampati:_____