BERTRAM DENTAL

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

Today's Date __________________ Name _____________________________________ I prefer to be called _______________________

DOB ______________________ SS# __________________________ Email Address _______________________________________

Address ____ City _____________________ Zip Code ____________________

Phone # ____________________ Cell # ______________________ Employer ___________________________ Phone # _______________

Emergency Contact Name and Phone # ____ Relation _________________________________

Physician _________________________________ Date of Last Physical Exam _________________ Date of Last Dental Exam ____________

I prefer to be contacted by: Phone Call ☐ Email ☐ Text Message ☐ Mail ☐ Other ____________________________

We are currently contacting patients by phone but may use other contact methods in the future unless otherwise specified.

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

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

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The information I have given today is correct to the best of my knowledge. I understand this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_______________________________________ ___________________

Signature Date

<u>Review of Medical History</u>

1. _______________________________________
Signature Date

2. _______________________________________
Signature Date

3. _______________________________________
Signature Date

4. _______________________________________
Signature Date