SUSAN HENSON
DMD, PA

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/St _____, _____ Zip Code_____

Hm (_____)_____-_____ Cell (_____)_____-_____ Employer_____Ph (_____)_____-_____

Emergency Contact Name _____ Ph# (_____)_____-_____ Relationship_____

Physician Name _____ Ph# (_____)_____-_____ Last Dental Exam _____/_____/_____

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

Breathing problems	**Y**	**N**	Diabetes	**Y**	**N**
Asthma	**Y**	**N**	Artificial Bones, Joints, Valves (circle one)	**Y**	**N**
History of tuberculosis (TB)	**Y**	**N**	Depression/Psychiatric Problems (circle one)	**Y**	**N**
High / Low blood pressure (circle one)	**Y**	**N**	Alcohol / Drug Abuse (circle one)	**Y**	**N**
Stroke	**Y**	**N**	Fibromyalgia	**Y**	**N**
Heart Attack or Angina (circle one)	**Y**	**N**	Sleep Apnea	**Y**	**N**
Heart Surgery/Pacemaker (circle one)	**Y**	**N**	Cancer (If yes, what type of cancer?)_____	**Y**	**N**
Congenital Heart Defect	**Y**	**N**	Chemotherapy	**Y**	**N**
Artificial Heart Valves	**Y**	**N**	Radiation Therapy	**Y**	**N**
Coronary Artery Disease	**Y**	**N**	ALLERGIES TO ANY OF THE FOLLOWING:		
Mitral Valve Prolapse	**Y**	**N**	Latex	**Y**	**N**
Rheumatic Fever	**Y**	**N**	Penicillin	**Y**	**N**
Ulcer, GERD, Colitis (circle one)	**Y**	**N**	Codeine, Aspirin, or other pain meds (circle one)	**Y**	**N**
Epilepsy/Seizures (circle one)	**Y**	**N**	Dental Anesthetics	**Y**	**N**
Liver Disease	**Y**	**N**	Other	**Y**	**N**
Hepatitis A, B, or C (circle one)	**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? **Y** **N** Are you interested in quitting? **Y** **N**

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? **Y** **N**

Please list each ***prescription*** drug you are taking:

_____

_____

_____

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**

Review of Medical History

_____/_____/_____ _____/_____/_____

Signature Date Signature Date