Mount Auburn Dental Health History 2017

*New patients…How did you hear about us? ____

______________________	______________________	______________________
First Name	Last Name	Date of Birth
Email	Telephone # best __	Cell # best __
Address	City/Town	Zip Code

Please check Yes or No for those that apply to you. If none apply please draw a line through the "no's" down the column.

Yes	No		Yes	No		Yes	No		Yes	No	
__	__	Anemia	__	__	Emphysema	__	__	Kidney Disease	__	__	Seizures
__	__	Arthritis	__	__	Excessive Bleeding	__	__	Liver Disease	__	__	Stomach Problems
__	__	Artificial Heart Valve	__	__	Fainting	__	__	Low Blood Pressure	__	__	Stroke
__	__	Artificial Joints	__	__	Glaucoma	__	__	Mitral Valve Prolapse	__	__	Thyroid Disease
__	__	Asthma	__	__	Heart Conditions	__	__	Nervousness/Depression	__	__	Tuberculosis
__	__	Blood Disease	__	__	Heart Lesions	__	__	Pacemaker	__	__	Ulcers
__	__	Bruise Easily	__	__	Heart Murmur	__	__	Periodontal Disease	__	__	Venereal Disease
__	__	Cancer	__	__	Heart Surgery	__	__	Radiation (Head/Neck)	__	__	Mental Health Issues
__	__	Chemotherapy	__	__	Hepatitis: A B C	__	__	Respiratory Problems	__	__	Birth Control
__	__	Diabetes	__	__	High Blood Pressure	__	__	Smoker	__	__	Nursing
__	__	Dizziness	__	__	HIV Positive	__	__	How many/day	__	__	Pregnant
__	__	Drug Addiction	__	__	Jaundice	__	__	Scarlet Fever			Delivery Date: ____________

Do you have any of the following drug allergies?

__	__	Aspirin	__	__	Latex	__	__	Percodan	Please list other allergies:
__	__	Codeine	__	__	Anesthetic	__	__	Penicillin	______________________
__	__	Darvon	__	__	Nitrous Oxide	__	__	Antibiotics	______________________
__	__	Erthromycin	__	__	Sulfa	__	__	Other Allergies	______________________

Please check any of the following drugs you have used at any time:

Yes	No		Yes	No		Yes	No		Yes	No	
__	__	Fosamax	__	__	Didronel	__	__	Zometa	__	__	Boniva
__	__	Aredia	__	__	Actonel	__	__	Skelid	__	__	Bisphosphonates

List ALL medications you currently take. (Prescription & Over-the-counter. Attach List if needed)

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Primary Physician: ____

Specialist: ____

I certify the information recorded on this medical form is correct. I understand it is my responsibility to notify Mount Auburn Dental of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Mount Auburn Dental or its employees liable in the event of death or injury.

Signature: (Patient/Guardian)________________________________ Date: ____________