Colliver Dental Group P.A.

Patient Name: _____**Pref. Name:** _____**Date of Birth:** _____

Address: _____

Phone Number(s): _____ **Email:** _____

Emergency Contact Name & Phone Number: _____

Insurance Name: _____**Employer:** _____ **ID Number:** _____

Policy Holder Name & Date of Birth: _____ **Soc. Sec #:** _____

Medical History Form

***Your mouth is a part of your entire body, therefore, health problems that you may have, or medication that you may be taking, could have an important relationship with any dental treatment you receive. ***

Are you under a physician's care now? **YES / NO** If **YES**, why? _____

Are you taking any medications? **YES / NO** If **YES**, please **LIST**: _____

_____

Preferred Pharmacy Name & Location: _____ Number: _____

Have you ever taken Fosamax, Boniva, Actonel or medications containing bisphosphonates? **YES / NO**

Do you need to pre-medicate? **YES / NO** For what? _____ Medication for pre-med: _____

Do you use cannabis? **YES / NO** Do you use tobacco, including vaping? **YES / NO**

Do you use controlled substances? **YES / NO** Are you on a special diet? **YES / NO**

Have you ever been hospitalized or had a major operation? **YES / NO** Have you ever had a serious head or neck injury? **YES / NO**

Have you ever been told you have periodontal disease? **YES / NO**

If **YES**, what treatment was performed? _____

Women: Are you pregnant? **YES / NO** Trying to get pregnant? **YES / NO** Nursing? **YES / NO** Taking contraceptives? **YES / NO**

Allergies (Please circle): **Sulfa, Aspirin, Penicillin, Codeine, Anesthetics, Metals, Latex, N/A** **Other:** _____

Do you have, or have had, any of the following? CHECK if YES.

Acid Reflux		Cold Sores		Heart Murmur		Pacemaker	
ADD/ADHD		Diabetes		Hepatitis A, B, or C		Psychiatric Care	
A-Fib		Drug Addiction		HIV/AIDS		Parkinson's disease	
Alzheimer's/Dementia		Dry Mouth		High Blood Pressure		Pain in jaw	
Anaphylaxis		Emphysema		High Cholesterol		Renal Disease	
Anemia		Epilepsy/Seizures		Herpes		Radiation	
Anxiety/Depression		Easily bruise		Hypoglycemia		Stroke	
Arthritis/Gout		Excessive bleeding		Liver Disease		Sinus trouble	
Artificial Heart Valve		Fainting spells		Low Blood Pressure		Shingles	
Artificial Joint		Frequent cough		Lung Disease		Sickle Cell	
Asthma		Glaucoma		Migraines		Sjogren's Disease	
Cancer		Hay Fever/Rash/Hives		Mitral Valve Prolapse		Tuberculosis	
Chemotherapy		Heart Attack		Osteoporosis		Thyroid Disease	
Chest Pain/Angina		Heart Disease		Organ Transplant		**Other:**	

Signature: _____**Date:** _____