Barton Street Dental

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Patient Name:

Last First MI

Preferred Name

Date of Birth

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *PreMed
- ☐ Allergy-Anesthetics
- ☐ Anemia
- ☐ Autoimmune Disease
- ☐ Blood Pressure-Low
- ☐ CHF
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Oral Ulcers
- ☐ Radiation/Chemo
- ☐ STD/HPV
- ☐ Tumors/Growths
- ☐ Abnormal Bleeding
- ☐ Allergy-medications
- ☐ Arthritis
- ☐ Bisphosphonate
- ☐ Blood Thinners
- ☐ Diabetes Type 1 or 2
- ☐ GI/Acid Reflux/Ulcer
- ☐ Heart Murmur/Defect
- ☐ Liver Disease
- ☐ Other
- ☐ Respiratory/COPD
- ☐ Stroke
- ☐ ADD/ADHD
- ☐ Allergy-Other
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Cancer
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Hepatitis A/B/C
- ☐ Mental Disorders
- ☐ Other
- ☐ Rheumatic Fever
- ☐ Thyroid Condition
- ☐ Alcohol/Drug recover
- ☐ Alzheimer's/Dementia
- ☐ Asthma
- ☐ Blood Pressure-High
- ☐ Chest Pain/Angina
- ☐ Eating Disorder
- ☐ Head/Neck/Jaw Injury
- ☐ HIV/AIDS
- ☐ Nervous Disorders
- ☐ Pacemaker/Stents
- ☐ Sinus Problems
- ☐ Tuberculosis

☐ Pregnant/Planning Pregnancy/Nursing/Taking Birth Control

☐ Have ever taken any medications with Biophosphonates? (Fosamax, Boniva, Actonel, or others)

Please clarify any conditions or alerts selected above including due date if pregnant:

Have ever had an orthopedic total joint (hip, knee, elbow or finger) replacement or a medical condition that requires you to take an antibiotic premedication for your dental visits? If yes, please explain. * Pre-Med

○ Yes ○ No

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

Are you taking any medications (prescription and Non-prescription), or recreational drugs. If yes please explain below * ◯ Yes ◯ No

Medications and dosage

Do you have any allergies and/or allergies to medications not previously listed. If yes, please explain below * ◯ Yes ◯ No

Allergies

Do you use tobacco products? * ◯ Yes ◯ No

If yes to the above, briefly describe your tobacco usage.

If there is any information you feel we should know about you that has not been presented in this questionnaire please describe below?

Please describe your oral hygiene habits.

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.

Name of Patient/Parent or Guardian completing this form *

Response Date: _____