UNITED IMPLANT DENTISTRY
6250 South Bay Rd, Cicero NY 13039
unitedimplant@icloud.com
P: 315.698.8888 F 315.699.8594

EMERGENY CONTACTS:

Name and relationship.	
Work Phone:	
Cell Phone:	
Home Phone:	
Email:	

PHARMACY INFORMATION:

Name	
Location	

'MINORS ONLY'

Father's Information

Name:	
Work Phone:	
Cell Phone:	
Home Phone:	
Email:	

Mother's Information

Name:	
Work Phone:	
Cell Phone:	
Home Phone:	
Email:	

REFERRAL:

How did you hear about us?

	Friend
	Drive By / Signature
	Internet Search
	Advertisement
	OTHER: _____

MEDICAL HISTORY

Heart Murmur (mitral valve prolapse) No Yes

Arthritis No Yes

Psychosis No Yes

Anemia No Yes

Diabetes No Yes

Epilepsy No Yes

Hepatitis, Any Form No Yes

Rheumatic Fever No Yes

Asthma No Yes

H.I.V Positive or AIDS Related Complex No Yes

Emphysema or other Respiratory Illnesses No Yes

Abnormal Heart Condition No Yes

Kidney Disease No Yes

Heart (Surgery, Disease, Attack) No Yes

Venereal Disease No Yes

Sore/Enlarged Lymph Nodes No Yes

Previous Biopsies No Yes

Slow-Healing Mouth Sores No Yes

Other Infections No Yes

Recurrent Illnesses No Yes

Joint Replacement No Yes

Glaucoma No Yes

Abnormal Bleeding from a cut	No	Yes
Liver Disease (including Jaundice)	No	Yes
Unintentional Weight Loss/Gain	No	Yes
Implants / Transplant	No	Yes
Previous Surgery.	No	Yes
Latex Sensitivity	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes
Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes
Herbal supplements?	No	Yes
Have you been treated with Bisphosphonate drugs?	No	Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S / D

Are you allergic or have you had a reaction to:

a. Local anesthetics …….. No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ……..…….. No Yes
d. Codeine, valium or other sedatives…… No Yes
e. Other _____

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____

Sugar in your diet: q None q Slight q Moderate q High

DOCTOR'S USE ONLY
Comments on patient interview concerning medical history:
_____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____	_____	_____
Patient (Print Name)	Patient Signature	Date
_____	_____	_____
Doctor (Print Name)	Doctor Signature	Date

UNITED IMPLANT DENTISTRY
6250 South Bay Rd, Cicero NY 13039
unitedimplant@icloud.com
P: 315.698.8888 F 315.699.8594

INFORMATION UPDATE **MEDICAL HISTORY**

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes
Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes
Rheumatic Fever	No	Yes
Joint Replacement	No	Yes
H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes

Are you a nursing mother? No Yes

Please list any medications you are currently taking:

1	4
2	5
3	6

Do you have any allergies? No Yes

List: _____

_____

_____

_____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____