PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY
PHONE: (916) 641-1200, FAX: (916) 641-1400

MEDICAL AND INSURANCE UPDATE

Name:_____ Date:_____

Address:_____ City/State/Zip:_____

Home Phone #_____Work Phone#:_____ Cell Phone#:_____ Dentist:_____

Name of Physician:_____ Physician Phone #:_____ Physician Fax #:_____

Last Medical Exam:_____ Birth Date:_____

Check any of the following conditions which you may have had or presently have:

☐Heart Trouble	☐Diabetes (or immed. Family)	☐Radiation/Chemotherapy
☐Congenital Heart Problems	☐Hepatitis A/B or Jaundice	☐Immunosuppresion
☐Heart Murmur	☐Ulcers	☐Hay Fever
☐Rheumatic Fever	☐Cancer or Tumor	☐Asthma
☐Heart Surgery	☐Persistant Cough	☐Joint Replacement
☐Cardiac Pacemaker	☐Sinus Problems	☐Psychiatric Care
☐Heart Valve Replacement	☐Tuberculosis	☐Substance Abuse
☐High Blood Pressure	☐Low Blood Pressure	☐Epilepsy
☐Stroke	☐Glaucoma	☐Kidney Disease

Has a physician ever directed you to take antibiotics prior to your teeth being cleaned or seeing the dentist?___yes __no

Do you have any medical problems including: diseases, conditions, problems or hospitalizations not listed above that you feel we should know about?
If so, please explain_____

Have you ever had an adverse reaction to local anesthetics? ____yes _____no

Do you smoke? If so how much?_____

Do you drink alcohol? If so how much?_____

Have you ever been diagnosed as having HIV/ARC/AIDS? _____yes _____no

If you are allergic to any medication, please list with type of reaction:_____
_____

If you are currently taking any medications, please list:_____
_____
_____

In case of an emergency, please notify:_____Hm #:_____ Wk#:_____

HAS THERE BEEN ANY INSURANCE CHANGE SINCE YOUR LAST VISIT?
If so, please complete the information below:
Employer:_____ Insurance Company_____
Group Plan Name:_____ Group #:_____
Subscriber and Birth Date:_____ ID #: _____

Patient's Signature:_____