MEDICAL ALERT: **AMIT M. PATEL, D.D.S., M.S.D.**

This information is requested in order that I may thoroughly diagnose and treat your condition safely.

Patient_____ **Spouse Name**_____ Date_____

Street Address_____ City_____ State_____ Zip_____

Home Phone _____ Bus. Phone_____ Cell_____ **DOB**_____

Email_____ SS# ____-____-____ Sex____ **Weight**_____ **Height**_____ Marital Status____

Occupation_____ Employer_____

Bus. Address_____ City/State/Zip_____

Physician_____ Phone_____

Dentist_____ Phone_____ Referrred by_____

Insured's Name_____ DOB _____ SS# ____-____-____

Employer_____ Address_____ City/State/Zip_____

Name of Dental Insurance_____ Person Responsible for payment_____

Emergency Contact_____ Phone_____ Relationship to Patient_____

MEDICAL AND DENTAL HISTORY

HAVE YOU EVER HAD:	Yes	No
Hepatitis or Liver Disease		
Epilepsy		
Kidney Disease		
Diabetes		
BSL _____		
Tuberculosis		
HIV +		
Heart Trouble		
Rheumatic Fever		
Heart Murmur		
High/Low Blood Pressure		
Shortness of Breath		
Chest Pains		
Radiation Treatment		
Surgery		
Arthritis		
Prostate Trouble		
Glaucoma		
Contact Lenses		
Psychiatric Treatment		
Thyroid Trouble		
Stomach Ulcers		
Sinus Problems		
Asthma or Hay Fever		
Allergies		
Unfavorable reaction to a drug		
Such as: Aspirin		
Barbiturates		
Dental Anesthetics		
Anesthetics		
Penicillin		
Sulfa drugs		
Demerol		
Codeine		
Other		
Any illness not listed		

	Yes	No
HAS a member of your family had diabetes? Who? _____		
ARE YOU: Presently under the care of a physician		
Date of last complete physical		
Taking any medication Please List: _____		
Such as: Antibiotics _____		
Anticoagulants (Aspirin)		
Cortisone		
Bisphosphonates		
Hormones:		
Medication for high blood pressure		
Birth control pills		
Subject to frequent urination		
Often thirsty		
Easily exhausted or fatigued		
Subject to frequent headaches		
Slow in healing		
Pregnant		
Experiencing menopause		
Post menopausal		
ARE YOU: A mouth breather		
Aware of grinding or clenching your teeth day or night		
Satisfied with the appearance of your teeth		

HAVE YOU:	Yes	No
Ever been told you had gum trouble		
Ever had trench mouth		
Ever been treated for Periodontal disease (Pyorrhea)		
Ever had Orthodontic treatment		
Had shifting of any teeth		
Had instructions on how to control plaque in your mouth		
Had immediate relatives lose all their natural teeth		
DO YOU: Have prolonged bleeding after injury or tooth extraction?		
Ever have sore or popping joints?		
Ever have sore teeth		
Have bad breath		
Have bleeding gums		
Have tooth sensitivity		
to heat		
to cold		
Use dental floss		
Use water pik		
Use hard toothbrush		
Use mouthwash		
Drink coffee		
Drink alcohol		
Smoke: now		
How much _____		
How long _____		
If no, did you smoke before?		
When did you stop?		
Have any fear of treatment		
Does tooth loss concern you?		
Have you ever considered implants?		

What is the reason for your visit?

_____

_____

_____

Patient's Signature_____ Dentist's Signature _____