Leipnitz Dental

Patient Information

Name_____Birthdate_____

Address_____

Email_____

Phone_____Cell_____

Medical Information

Physician Name_____Clinic Name_____

Pharmacy Name_____

Please list any allergies:

_____

_____

Please list all medications you are taking:

_____

_____

Please list any serious illnesses, injuries, or surgeries you have had:

_____

Have you taken or are you currently taking bisphosphonates?

(example: Fosamax, Boniva, Actonel)……Y/N

Are you using oral contraceptives?……Y/N

Do you smoke or chew tobacco?……Y/N

SEE REVERSE SIDE

Circle any of the following which you have had:

Anemia
Angina
Artificial Heart Valve
Blood Disease
Congenital Heart Def
Heart Attack
Heart Condition
Heart Murmur
Heart Surgery
Hemophilia
High Blood Pressure
High Cholesterol
Irregular Heart Beat
Leukemia
Mitral Valve Prolapse
Pacemaker
Rheumatic Fever
Stents
Stroke, If so, when?
_____

Acid Reflux
Stomach Ulcers

AIDS
Arthritis
Rheumatoid Arthritis
Cancer, list type
_____
Chemotherapy
Radiation
Herpes
HIV Positive
HPV
Scarlet Fever
Sexually Tran Dis.

Diabetes (1 or 2)
Insulin Dep. Diabetes
Thyroid problem
Cirrhosis
Hepatitis A /B /C
Jaundice
Kidney Disease
Dialysis
Liver Disease
Asthma
Bronchitis
COPD
Emphysema
Mouth Breathing
Respiratory Problems
Sinus Problems
Sleep Apnea
Tuberculosis
Use Inhaler

Aspergers Syndrome
Autism
Cerebral Palsy
Dizzy Spells/Fainting
Epilepsy or Seizures
Intellectual Disability
Anxiety/Depression
Nervous Disorder
Nursing
Pregnant
Due Date_____

Artificial Joints
Osteoporosis

Detached Retina
Glaucoma
Lupus (SLE)
Parkinson's Disease
Alzheimers Disease
Drug/Alcohol Abuse
MRSA

Signature _____