Patient Information

Patient Name: ________________________________ Home #: (____) _____-_______Cell #: (____) _____-______

Address: ____ City: __________________ St:____ Zip: ____________

Social Security #: _________________ Date of Birth: ___/_____/______ Height: ________ Weight: _________

Email: _______________________________________May we contact you through email: Yes ☐ No ☐

Dental Insurance Company: _______________________________ Policy ID#: ____________________________

Group #: ______________ Subscriber Name: ______________________ Subscriber Date of Birth: ___/___/___

Subscriber Employer: __________________________ Subscriber Social Security # ________________________

Emergency Contact Name:_______________________ Emergency Contact Phone Number _________________

Marital Status:_____________________ How did you hear about our office? ___________________________

Medical History

1. Are you in good general health?..Yes ☐ NO ☐
2. Have there been any changes in your general health in the past year?.................................Yes ☐ NO ☐
3. My last physical examination was on, approximate date..__/_____/______
4. Are you presently under a physician's care?..Yes ☐ NO ☐
   If YES, what conditions are being treated: ____

____

5. What is your general practitioner's name?_______________________& phone number? ----------------- _______
6. Have you had any serious illness or operation?...Yes ☐ NO ☐
7. Do you have or have you had any of the following? Please check all that apply: ☐ None

☐ Heart Trouble ☐ Heart Attack ☐ Mitral Valve Prolapse

☐ Coronary Insufficiency ☐ Damaged Heart Valves ☐ Congenital Heart Disease/ Defects

☐ Stroke ☐ Cardiac Pacemaker ☐ High ☐ Low Blood Pressure

8. Please list all Medications you are currently taking: (additional form included for extensive med list)

   ____

   ____

9. Do you have or have had a Substance abuse problem?... Yes ☐ NO ☐
   If yes, how long have you been in recovery? ____________________________________
10. Chest pain upon exertion?..Yes ☐ NO ☐
11. Do you have or have you had any of the following? Please check all that apply: ☐ None

☐ Epilepsy ☐ Fainting Spells ☐ Seizures
☐ Emotional Disturbances ☐ Depression ☐ Anxiety

12. Do you have sinusitis or sinus trouble? Please circle which one...Yes ☐ NO ☐
13. Do you have emphysema, chronic bronchitis, or asthma? Please circle which one.................Yes ☐ NO ☐
14. Do you have ANY stomach ulcers?...Yes ☐ NO ☐
15. Do you have or have you had any of the following? Please check all that apply: ☐ None

☐ Acid Reflux (GERD) ☐ Hepatitis ☐ Jaundice ☐ Liver Disease

16. Have you ever vomited blood?...Yes ☐ NO ☐

17. Do you have ANY diarrhea?..Yes ☐ NO ☐

18. Do you have diabetes?..Yes ☐ NO ☐
    If YES, when was your most recent blood sugar test/A1C_______________________________
    Type 1 or Type 2? _______________________________
    How long have you been a diabetic? ___________________
19. Do you have hypothyroidism or hyperthyroidism? Please circle which one...........................Yes ☐ NO ☐
20. Do you have anemia, Sickle Cell Disease, or any other blood disorder?................................Yes ☐ NO ☐
21. Have you had any abnormal bleeding after surgery, extraction, or trauma?..........................Yes ☐ NO ☐
22. Do you have an autoimmune disease?..Yes ☐ NO ☐
    If YES, what condition, is it being treated, and how:

____

23. Are you allergic to or have you reacted adversely to any medications listed below: ☐ None

☐ Local Anesthetic ☐ Antibiotics ☐ Penicillin ☐ Sulfa Drugs

☐ Barbiturates ☐ Sedatives ☐ Sleeping Pills ☐ Aspirin

☐ Iodine ☐ Codeine ☐ Latex ☐ Other: ____________

24. Do you have asthma, hay fever or other seasonal allergies? Please circle which one...............Yes ☐ NO ☐
25. Do you have or have ever had hives or a skin rash?.. Yes ☐ NO ☐
26. Do you have or have you ever had kidney trouble or dialysis?..Yes ☐ NO ☐
27. Do you have or have you ever had syphilis, gonorrhea, or any other STDs?............................Yes ☐ NO ☐
28. Do you have or have you had any of the following? Please check all that apply: ☐ None
    ☐ Arthritis ☐ Osteoporosis ☐ Bone Infection ☐ Inflammatory Rheumatism

    ☐ Artificial Joint Replacement

29. Have you received or are you currently receiving the intravenous medication known as bisphosphonate?
    ☐ Yes ☐ NO
30. Do you have or have you had a tumor or malignancy?...Yes ☐ NO ☐
31. Do you use tobacco? Smoke? Chew? Vape? Please circle which applies................................. Yes ☐ NO ☐
32. Do you or have you used any illegal substances?...Yes ☐ NO ☐
    If so, what have you used, what was your last use and how much and how often?

    ____
33. For women, are you pregnant?...Yes ☐ NO ☐
34. Are you nursing?..Yes ☐ NO ☐
35. Are you taking oral contraceptives?...Yes ☐ NO ☐
36. Are you undergoing hormonal therapies?..Yes ☐ NO ☐

Are there any other conditions or health concerns not listed above? If so, please explain:

____

Doctor Notes: ____

____

To the best of my knowledge the information in this form is accurate and true.

Signature of Patient or Guardian:_______________________________________ **Date:**________

Signature of Doctor:____ **Date:** ________

Patient Medication List

Texas Sedation Dental & IMPLANT CENTER

Today's Date: ____________

Printed Name: ________________________

ALLERGIES AND REACTIONS (PLEASE LIST ALL ALLERGIES AND REACTIONS TO MEDICATIONS, FOOD, LATEX, TAPE)
☐ NO KNOWN ALLERGIES

What Pharmacy Do You Use? ______________________________ Location of Pharmacy ___________________

List below all of the medications you take including OVER THE COUNTER and ALTERNATIVE REMEDIES INCLUDING HERBAL MEDICATIONS. Please note if you do not know or cannot remember all of the medications you take. Always bring a list of every medication you take to every medical appointment.

Medication Name	Dose (How many mg, mcg?)	How Often? (Once a day, twice a day, before meals or as needed)