IMPLANT & PERIODONTAL CLINIC

DAVID A BAKER DDS MSD

Specializing in Dental Implants & Periodontal Care

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INFORMATION AND HEALTH HISTORY

Today's date: _____

Name: _____ Date of Birth: _____
First Middle Last

Mailing Address: Street _____

City _____ State _____ Zip _____

Residence address if not the same: _____

Email Address: _____ Do you want to get appt. reminders via email? _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Occupation: _____ Employer: _____

Spouse's Full Name: _____ Date of Birth: _____

Occupation: _____ Employer: _____

* * * * * * * * * * * * * * * * *

Insurance Info: Primary Dental Ins: _____ Secondary Dental Ins: _____

Subscriber: _____ Subscriber: _____

SS # or ID #: _____ SS # or ID #: _____

Date of Birth: _____ Date of Birth: _____

Group #: _____ Group #: _____

* * * * * * * * * * * * * * * * *

Referred by: _____ General Dentist: _____ How long? _____

Previous Dentist: _____ How long? _____ Last Exam? _____

Physician Name: _____ Date of Last Exam: _____

* * * * * * * * * * * * * * * * *

Name, address & phone # of close friend or relative: _____

*** Please fill out back side ***

For Office Use Only:

Reviewed by: _____ Date: _____

1. Do you presently have any dental problems? Explain _____

_____

2. Do your gums bleed? Yes _____ No _____

3. Have you experienced prolonged bleeding or slow healing after any tooth extraction? Yes _____ No _____

4. Please describe any current medical treatment or impending surgery: _____

_____

_____

5. Have you been hospitalized in the last 5 years? _____

6. Are you a former smoker? _____ Current smoker? _____ How much? _____

7. Osteoporosis treatment: Have you ever had injectable treatments? (Zometa or Boniva) _____ When? _____

Have you ever taken pills for osteoporosis? (Fosamox) _____ When did you start treatment (year)? _____

8. Have you had any joints replaced? Yes _____ No _____ If yes, please list. _____

_____

9. Do you have an artificial heart valve? Yes _____ No _____

10. Do you take daily aspirin or a blood thinner? Yes _____ No _____

11. Please circle any of the following, which you have had in the past or present:

a. Heart trouble
b. Heart murmur
c. High / Low BP
d. Chest pains
e. Rheumatic fever
f. Jaundice / liver
g. Hepatitis A, B, C
h. Cancer _____
i. Radiation treatment
j. Lung problems
k. Emphysema
l. Tuberculosis
m. Asthma / Hay Fever
n. HIV / AIDS
o. Sinus trouble
p. Diabetes _____
q. Glaucoma
r. Ulcer
s. Kidney disease
t. Stroke
u. Epilepsy / seizure
v. Arthritis
w. Fainting spells
x. Anemia / blood disorder
y. Psychiatric care
z. Osteoporosis
aa. Herpes
bb. Artificial joints
cc. Blood transfusion
dd. Pacemaker
ee. Thyroid condition
ff. Addiction
gg. Sleep Apnea
hh. Multiple Sclerosis

12. a. Do you take any prescription medications? If yes, list below: _____

_____

b. Over the counter medications? _____

_____

13. Latex Allergy? Y__N__ Medication Allergy? Y__N__ Penicillin Allergy? Y__N__ Sulfa Allergy? Y__N__

Other Allergies (list): _____

14. Women: Are you pregnant? Y__N__ Taking birth control? Y__N__ Taking hormones? Y__N__

Patient Signature: _____ Date: _____