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, impending surgery, or other treatment that may affect your dental health. _____

_____

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. 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

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

_____

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

11. Do you take daily asprin or a blood thinner? Yes _____ No _____

12. List any medicines you take regularly, either over the counter or prescription. Please list medications and conditions (example: Lipitor / Cholesterol) **If you have a List of Medications that we can take a copy of, we would be happy to do so.** _____

_____

12. Latex Allergy ? _____ Medication Allergy ? _____ Penicillin Allergy? _____ Sulfa Allergy? _____
Other Allergies ? _____

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

Patient Signature _____ Date: _____

IMPLANT & PERIODONTAL CLINIC

DAVID A BAKER DDS MSD
KANAKO J NAGATOMO DDS MSD PHD

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3628 Meridian # 2-C • Bellingham, WA 98225

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 _____

Home Phone #: _____Cell Phone # _____ Work # _____

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

Occupation _____ Employer: _____

Spouses 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:_____

_____