WEST KALAMAZOO DENTAL CARE

Medical History

Today's Date:_____

Patient Name: _____Birth Date:_____

I. PLEASE CIRCLE APPROPRIATE ANSWER FOR EACH:

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart Disease	Yes	No	Difficulty swallowing	Yes	No	Arthritis/Rheumatism
Yes	No	Heart Attack	Yes	No	Diarrhea/Constipation	Yes	No	Artificial Joint/ Replacement
Yes	No	High Blood Pressure	Yes	No	Vomiting/Nausea	Yes	No	AIDS/HIV
Yes	No	Chest Pain (Angina)	Yes	No	Bloody Stool/Urine	Yes	No	Herpes Simplex
Yes	No	Congenital Heart Defect/ disease	Yes	No	Stomach Problems/Ulcers	Yes	No	Skin Disease
Yes	No	Infection of the Heart or Blood	Yes	No	Thyroid/Adrenal Dysfunction	Yes	No	Eye Disease
Yes	No	Prosthetic Heart Valve	Yes	No	Headaches/Dizziness	Yes	No	Cancer
Yes	No	Pacemaker/Implanted Device	Yes	No	Fainting	Yes	No	Radiation Treatments
Yes	No	Stroke	Yes	No	Seizures	Yes	No	Chemotherapy
Yes	No	Bleeding Problems	Yes	No	Increase Thirst/Urination	Yes	No	Blood Transfusion
Yes	No	Blood disease/disorders	Yes	No	Diabetes	Yes	No	Psychiatric care
Yes	No	Anemia	Yes	No	Kidney Disease	Yes	No	Tobacco (any form)
Yes	No	Sinus Problems	Yes	No	Hepatitis/Liver Disease	Yes	No	Alcoholism
Yes	No	Asthma	Yes	No	Dry Mouth	Yes	No	Recreational Drugs
Yes	No	TB (Tuberculosis)	Yes	No	Joint Pain/Stiffness	Yes	No	Are you Pregnant/ Nursing
Yes	No	COPD/Emphysema	Yes	No	Osteoporosis	Yes	No	Taking Birth Control
						Yes	No	Diagnosis Sleep Apnea

PLEASE LIST ANY OTHER DISEASES/MEDICAL CONCERNS: _____

II. ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?

Penicillin Codeine Aspirin Nitrous Oxide Local Anesthetic Latex Motrin/Ibuprofen

PLEASE LIST ALL OTHER ALLERGIES: _____

III. PLEASE PROVIDE A LIST OF ALL MEDICATIONS YOU ARE TAKING AND WHAT THEY ARE FOR:

_____

_____

IV. PLEASE LIST ALL HOSPITALIZATIONS/SURGERIES/PROCEDURES IN THE PAST 10 YEARS:

To the best of my knowledge, I have answered all questions completely and accurately. I will inform my dentist of any changes in my health and/or medications at each visit.

☑ Patient Signature:_____Date:_____

WEST KALAMAZOO DENTAL CARE

Daniel M. Bonine DDS

Patient Information

Today's Date: _____

Patient Name: _____
Last First Middle Preferred Name

Social Security Number (SSN):_____ Marital Status: _____

Birth Date: _____ Gender: _____ Employer: _____

Address: _____
Street City State Zip

Phone: _____
Cell (receive text messages) Home Work

Email: _____

Whom may we thank for referring you to our office: _____

Responsible Parent/Guardian Name: _____
Last First Middle

Birth Date: _____Gender: _____ Occupation/Employer: _____

Address: _____
Street City State Zip

Phone: _____
Home Work Cell Preferred

Consent for Dental Treatment:

I give consent for dental treatment for the patient named above to the health care providers at West Kalamazoo Dental Care. I understand there are some risks inherent to all dental procedures, including the administration of local anesthetics and drugs common to dental practice. I understand I am free to ask any questions regarding proposed treatment and risks involved.

☑ Signature of Patient, Parent or Guardian: _____ Date: _____

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