West Kits Dental – Patient Medical Form

PERSONAL INFO:

First Name: _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____

Mobile: _____ 2nd Phone: _____ Work Phone: _____

Birthday (M/D/YEAR) _____ Employer/Occupation: _____

REFERRED BY (*how did you find out about this clinic?) _____

Medical Doctor: _____ Your Email: _____

MEDICAL HISTORY:

****List Medical Allergies:** _____ _____ _____

1) Have you ever had a serious illness or are you under the care of a medical doctor now? YES NO
2) Have you had a medical examination in the last year? YES NO
3) Have you ever had any of the following diseases: (**CHECK ALL THAT APPLY**)
Jaundice ____ Epilepsy ____ Cancer ____ Tuberculosis ____ Kidney disease ____
Diabetes ____ Arthritis ____ Stroke ____ Lung disease ____ Thyroid Disease ____
Hepatitis ____ High Blood Pressure ____ Heart Attack ____ Heart disease ____
Rheumatic Fever _____ Gastrointestinal Disease ____ Venereal Disease (STD) ____
Mental or Anxiety disorder ____

4) Have you ever tested positive for HIV or AIDS? YES NO
5) Do you have (**check all that apply**): Asthma _____ Hay Fever _____ Hives _____ Skin Rashes _____
6) Have you experienced any unusual /reversed reaction to the following drugs: (**check ALL that apply**):
Aspirin _____ **Iodine** ____ **Barbiturates** ____ **Sulfa Drugs** ____ **Penicillin** _____

****Have You experienced any unusual reaction to local anesthetic ("freezing")? YES NO**

7) Do you bruise easily/abnormally? YES NO
8) Is there a history of family disease (i.e., Diabetes, cardiovascular disease, cancer, etc.) IF YES, What?

_____

9) **WOMEN ONLY** Are you possibly pregnant? IF YES, what month? _____ NO

****List of Medications:** _____ _____

_____ _____

DENTAL HISTORY:

What dental condition concerns you presently? _____

Have you had a regular dental examination in the past? (1x 6 months OR 1x yearly) YES NO
Have you had any teeth extracted due to (**Check all that apply**):

Accident _____ Decay _____ Gum Disease ____ OTHER: _____
Do you have any oral habits such as: Clenching _____ Grinding _____ Nail biting _____
Have you had: Fixed bridges _____ Partial Dentures _____ Complete Dentures _____
Crowns _____ Root Canal Therapy _____ Periodontal (Gum) Treatment _____
Abscessed tooth/teeth _____ Sore Mouth _____ Bleeding Gums _____

PATIENT'S SIGNATURE: _____ **DATE:** _____
I understand I am required to provide at least 48 HR advance notice to avoid a possible charge of $75.00 If I wish to cancel/reschedule a dental appointment. Initials: _____