



UNITED IMPLANT DENTISTRY
6250 South Bay Rd, Cicero NY 13039
unitedimplant@icloud.com
P: 315.698.8888 F 315.699.8594

EMERGENCY CONTACTS:

Name and relationship.

Work Phone:

Cell Phone:

Home Phone:

Email:

PHARMACY INFORMATION:

Name

Location

'MINORS ONLY'

Father's Information

Name:

Work Phone:

Cell Phone:

Home Phone:

Email:

Mother's Information

Name:

Work Phone:

Cell Phone:

Home Phone:

Email:

REFERRAL:

How did you hear about us?

	Friend
	Drive By / Signature
	Internet Search
	Advertisement
	OTHER: _____

MEDICAL HISTORY

Heart Murmur (mitral valve prolapse)	No	Yes		
Arthritis	No	Yes		
Psychosis	No	Yes		
Anemia	No	Yes		
Diabetes	No	Yes		
Epilepsy	No	Yes		
Hepatitis, Any Form	No	Yes		
Rheumatic Fever	No	Yes		
Asthma	No	Yes		
H.I.V Positive or AIDS Related Complex	No	Yes		
Emphysema or other Respiratory Illnesses	No	Yes		
Abnormal Heart Condition	No	Yes		
Kidney Disease	No	Yes		
Heart (Surgery, Disease, Attack)	No	Yes		
Venereal Disease	No	Yes		
Sore/Enlarged Lymph Nodes	No	Yes		
Previous Biopsies	No	Yes		
Slow-Healing Mouth Sores	No	Yes		
Other Infections	No	Yes		
Recurrent Illnesses	No	Yes		
Joint Replacement			No	Yes
Glaucoma			No	Yes

Abnormal Bleeding from a cut	No	Yes
Liver Disease (including Jaundice)	No	Yes
Unintentional Weight Loss/Gain	No	Yes
Implants / Transplant	No	Yes
Previous Surgery.	No	Yes
Latex Sensitivity	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes
Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes
Herbal supplements?	No	Yes
Have you been treated with Bisphosphonate drugs?	No	Yes

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually: S / D

Are you allergic or have you had a reaction to:

- | | | |
|---|----|-----|
| a. Local anesthetics | No | Yes |
| b. Penicillin or other antibiotics | No | Yes |
| c. Aspirin | No | Yes |
| d. Codeine, valium or other sedatives..... | No | Yes |
| e. Other _____ | | |

Are you a smoker? No Yes

If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: q None q Slight q Moderate q High

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

Doctor (Print Name)

Doctor Signature

Date



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INFORMATION UPDATE **MEDICAL HISTORY**

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes
Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes
Rheumatic Fever	No	Yes
Joint Replacement	No	Yes
H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes

Are you a nursing mother? No Yes

Please list any medications you are currently taking:

1	4
2	5
3	6

Do you have any allergies? No Yes

List: _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____