Berkers Family Dentistry

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip_____

Home Phone: _____ Cell Phone: _____ Employer: _____

Health Information

Please check any that apply:

__Abnormal bleeding
__Difficulty breathing
__Acid Reflux
__ADD or ADHD
__Alcohol or drug abuse
__Anemia
__Mitral Valve prolapse
__Anxiety
__Arthritis
__Artificial bones/joints/valves
__Asthma/COPD
__Pregnant, due date_____
__Sinus problems

__Blood Transfusion
__High/low blood pressure
__Emphysema
__Blood Transfusion
__Cancer/Chemotherapy/Radiation
__Colitis
__Osteoporosis
__Congenital heart defect
__Diabetes
__Hospitalized- reason_____
__Pacemaker/Defibrillator
__Rheumatic/Scarlet Fever
__Thyroid problems

__Herpes/fever blisters
__HIV/AIDS
__kidney problems
__Fainting Spells
__Frequent Headaches
__ Lupus
__Heart Attack
__Heart Murmur
__Heart surgery
__Liver disease
__Seizures
__Stroke
__Ulcers

Circle which apply:
Do you have bleeding gums, pain in or near ears, difficult extractions, mouth sores, or grind teeth?
Physician: _____
Any known allergies_____
Are you currently taking any blood thinners? __yes ___ no
If you ***premedicate*** before dental visits, indicate drug and dosage._____
Have you ever taken Fosamax, Aredia, Actonel, or Zometa? __yes __no
Please list all medications you are taking
_____
_____

Are you happy with your smile? ___yes __ no Would you like a whiter smile? ___yes __no

Signature: _____ Date: _____
(Patient or Guardian)
Email address for confirming _____

Over >>>>