



Scott D. Anderson D.D.S.
Fellow International Congress of Oral Implantologists

1 ABOUT YOU

Today's Date: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

City State Zip

Hm #: (_____) _____ Pager/Cell #: (_____) _____

Wk#: (_____) _____ Ext: _____

E-Mail Address: _____

Employer: _____

Occupation: _____

Whom may we Thank for referring you? _____

Emergency Contact

His / Her Name: _____ Relation: _____

Wk #: (_____) _____ Hm #: (_____) _____

Address: _____
City State Zip

2 FAMILY HISTORY

Spouse/Partner Name: _____

Wk#: (_____) _____ Ext: _____

Other Family Members seen by this office: _____

3 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (_____) _____

Are you currently under the care of a physician? Yes No

Please explain: _____

Have you had any metal rods, pins or implants? Yes No

Do you require antibiotics before dental treatment? Yes No

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one: _____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week# _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits
<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Latex	<input type="checkbox"/> Y <input type="checkbox"/> N Other
<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	

Please list any other drugs/materials that you are allergic to: _____
