gentle dental CARE
STATE-OF-THE-ART COMFORTABLE CARE

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

TOOTH CONSERVING DENTISTRY · DENTAL IMPLANTS

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306 North Main Street
Gunnison, CO 81230

1 ABOUT YOU

Today's Date: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ❍ Male ❍ Female

Birthdate: _____/_____/_____ Age:_____

Home Address: _____
Apt/Condo #

_____
City State Zip

Hm #: (_____) _____ Cell #: (_____) _____

Wk#: (_____) _____ Ext:_____

E-Mail Address:_____

Employer:_____

Occupation:_____

Whom may we Thank for referring you? _____

Emergency Contact

His / Her Name: _____ Relation: _____

Cell #: (_____) _____ Hm #: (_____)_____

Address: _____

_____
City State Zip

2 FAMILY HISTORY

Spouse/Partner Name:_____

Cell #: (_____) _____

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 joint replacements? ❍ Yes ❍ No
Where?_____ Date_____

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?

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

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

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

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

_____

Patient Signature:_____ Date:_____