ConfiDent
Dental Implant Center

MEDICAL/DENTAL HISTORY **Date**_____

Name DOB Sex: M/F Height Weight

It is important to know about your medical/dental history. Please answer the following questions. Information provided is strictly confidential and will not be released without your permission.

1. What is your chief dental complaint: _____
   _____
2. If you could improve your current dental condition, what would you like to be done? _____
   _____
3. Have you had any serious trouble associated with previous dental treatment? ….....Yes / No
   If yes, please explain. _____
4. Are you wearing removable dental appliances? ….....Yes / No
5. Are you in generally good health? ….....Yes / No
6. Do you have or have you ever had any major medical problems? ….....Yes / No
   If yes, please explain. _____
   _____
7. Are you under the care of a physician? ….....Yes / No
   If yes, for what condition? _____
8. Name and address of my physician is: _____
   _____
9. Have you had any serious illness, operation, or hospitalization within the past 5 years? ……Yes / No
   If yes, please explain._____
10. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Atonel, Boniva, Aredia, or Zometa)? ……...Yes / No
11. Do you smoke or chew tobacco? ……Yes / No
    If yes, how much?_____
12. Are you wearing contact lenses? ……Yes / No
13. Do you wish to talk to the doctor privately about anything? ….....Yes / No

Women

14. Are you pregnant or trying to become pregnant? ……...Yes / No
15. Do you have problems associated with your menstrual period? ……Yes / No
16. Are you nursing? ……Yes / No
17. Are you taking birth control pills? …… Yes / No

Emergency Contact Name/Number _____ Relationship _____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature:_____ **Date:**_____