DENTAL IMPLANT CENTER
OF ROYAL OAK

Registration & Medical History

First Name: ______________________________ Middle Initial: ______ Last Name: ______________________________

Sex: **M** **F** Marital Status: **S** **M** **D** **W** Date of Birth: ________________________ Age: _____________

Street Address: ____ Apt #: ________________

City: ____ State: ___________ Zip Code: _____________________

Cell Phone: ______________________ Home Phone: ______________________ Work Phone: ______________________

Email: ____ Social Security #: __________________________

Employer: __________________________ Position: ____________________ Primary Physician: ___________________

Pharmacy: _________________________________ Cross Streets or Phone Number: ______________________________

Emergency Contact: ____________________________ Relationship: _________________ Phone: ___________________

Dental Insurance: **Y** **N** (if no, please skip to medical history)

Company: ____________________ Name of Insured: _______________________________ Relationship: _____________

Insured Birth Date: ________________ Insured Employer: _______________________ ID #: _______________________

Y **N** Do you consider yourself to be in good medical health? Date of last medical check up: ______________________

Y **N** Are you taking ANY medications/vitamins (i.e. fish oil, etc.) If yes, please list: ______________________________

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Y **N** Do you normally pre-medicate with ANTIBIOTICS prior to dental treatment? ______________________________

Y **N** Are you currently being treated by a medical doctor? If so, for what? ____________________________________

Y **N** Have you ever had any injury to your face or jaw? If yes, please explain: ________________________________

Y **N** Do you smoke or chew tobacco? How much? _________

Y **N** Do you consume alcohol? How much? _________

Y **N** Are you allergic to or react to any medications/drugs/foods (i.e. penicillin, aspirin, codeine, lidocaine, latex, peanuts, etc.)? If so, please list: ____

Y **N** Do you use recreational drugs (i.e. cocaine, etc.)? ____

Y **N** Are you ever short of breath with mild exertion? Please explain: ____

Y **N** Have you been hospitalized recently? Why? _________________________________ When? ________________

Y **N** Have you had any surgeries within the past year? ______________________________ When? _______________

<u>Have you ever had any of the following?</u>

Y **N** Heart Disease (valve replacement, bypass, pacemaker, mitral valve prolapse, heart murmur, stent, angioplasty, etc.)

Y **N** Epilepsy or Seizures

Y **N** Blood Pressure: HIGH LOW

Y **N** Cancer

Y **N** Ulcers

Y **N** Diabetes: TYPE I TYPE II

Y **N** Glaucoma

Y **N** Kidney Disease

Y **N** Bleeding Problems (inability to clot)

Y **N** AIDS or HIV

Y **N** Hepatitis A B C

Y **N** Women: Are you pregnant?

Y **N** Lung Disease (TB, COPD, asthma, emphysema, etc.)

Y **N** Rheumatic Fever/Infective Endocarditis

Y **N** Radiation Treatments

Y **N** Arthritis

Y **N** Sinus Trouble

Y **N** Joint Replacement - HIP KNEE OTHER: ______

Y **N** Psychiatric Treatment

Y **N** Liver Disease

Y **N** Blood Disease (anemia, leukemia, sickle cell)

Y **N** Blood Thinners (Plavix, Coumadin, Xarelto, Eliquis)

Y **N** Women: Are you taking any contraceptives?

Y **N** Are you taking or have you taken any Osteoporosis medications (i.e. Fosamax, Boniva, Prolia, Actonel, Forteo)

Please describe any other medical or dental treatment that the doctor should know about: __________________________

Patient/Guardian Signature: ______________________________ **Date:** ____________ **Doctor Initials:** ______________