Denture and Dental Services

Peter M. Masone, DDS

12671 Emerald Coast Pkwy
Fountain Plaza Suite 205/206
Destin, Fl 32550

Date: _____

Patient Name _____ D.O.B. _____

Address _____ City _____ State ____ ZIP _____

SSN _____ Phone _____ Email _____

Employer: Name _____ Phone _____

Emergency Contact: Name _____ Phone _____

How did you hear about us? _____

When was your last dental exam _____ Dentist's Name _____

Why have you come to see us today? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Physician's Name: _____
Clinic Name : _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been involved in a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Have you received or are you currently receiving any of the following drugs: Fosamax, Actonel, Boniva, Aredia or Zometa? ☐ Yes ☐ No If yes, please explain: _____

Do you reqiure a PreMed? ☐ Yes ☐ No If yes, please explain: _____

Women: Are you… ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐	Acrylic	☐	Aspirin	☐	Codeine	☐	Latex
☐	Local Anesthetics	☐	Metal	☐	Penicillin	☐	Sulfa Drugs
☐	Tetracycline	☐	Other: _____				

Primary Dental Insurance: _____ Phone _____

Address: _____

_____

Group #: _____

Do you have, or have you had, any of the following?

☐	**AIDS / HIV Positive**	☐	**Epilepsy or Seizures**	☐	**Pacemaker**
☐	**Alzheimer's Disease**	☐	**Excessive Bleeding**	☐	**Pregnancy**
☐	**Anemia - Chronic**	☐	**Glaucoma**	☐	**Pre-Medication**
☐	**Angina Pectoris**	☐	**Heart Attack / Congestive Heart Failure**	☐	**Psychiatric Care**
☐	**Antipsychotic Medications**	☐	**Heart Murmur *Only if Pre-Med is required**	☐	**Radiation / Chemotherapy**
☐	**Arthritis**	☐	**Heart Valve Replacement**	☐	**Respiratory Problems**
☐	**Artificial Heart Valve**	☐	**Hepatitis**	☐	**Rheumatic Fever**
☐	**Artificial Joint**	☐	**Herpes**	☐	**Rheumatism**
☐	**Asthma**	☐	**High Blood Pressure**	☐	**Shingles**
☐	**Autism**	☐	**Kidney Disease**	☐	**Spina bifida**
☐	**Cancer**	☐	**Leukemia**	☐	**Stomach Problems**
☐	**Chemical Dependency Alcohol / Drugs**	☐	**Liver Disease**	☐	**Stroke**
☐	**Congenital Heart Disorder / Defect**	☐	**Meniere's Disease (Dizziness)**	☐	**Thyroid Disease**
☐	**Coagulation Disorder**	☐	**Mental Disorder**	☐	**Tuberculosis**
☐	**Coumadin Therapy**	☐	**Mitral Valve Prolapse**	☐	**Tumors**
☐	**Crohn's Disease**	☐	**Nervous Disorder**	☐	**Ulcers**
☐	**Depression**	☐	**Organ Transplant**	☐	**Venereal Disease / STD's**
☐	**Diabetes**				

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____