RIVERSIDE FAMILY DENTAL

Patient Name_____
Date of Birth_____

MEDICAL HISTORY

Please mark (x) to your response to indicate if you have or have had any of the following:

- ☐ Acid reflux
- ☐ Stomach ulcers
- ☐ Celiac disease
- ☐ GI disease-other
- ☐ Angina/chest pain
- ☐ Artificial heart valve
- ☐ Heart attack
- ☐ Stent
- ☐ Heart condition-other
- ☐ High Blood pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Lung disease-other
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Jaw joint pain
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Autoimmune disease: _____
- ☐ Blood disease
- ☐ Bleeding disorder
- ☐ Fainting
- ☐ Seizures
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Cancer, specify: _____
- ☐ Radiation Therapy
- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Psychiatric Illness-other
- ☐ Autism
- ☐ Narcotic use
- ☐ Marijuana use
- ☐ Tobacco use
- ☐ Alcohol use

Women:

- ☐ Nursing
- ☐ Pregnant

Other medical conditions or concerns: _____

Allergies:_____

Primary Care Physician Name_____

Have you had a serious Illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain_____
_____

Are you taking or have you recently taken any prescription or over the counter medications? Y or N, If yes please list all, including vitamins, natural or herbal supplements and/or dietary supplements _____
_____
_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medication:_____

Have you ever had surgery? If so, what type:_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

Signature of Patient _____ Date _____