Cove Dental Care Medical History

Name: ______________________ **Name of Physician**: __________________ **PH. #** ______________

1. ALLERGIES: Penicillin/Antibiotics **Y/N** Anesthetics **Y/N** Metals **Y/N** Latex **Y/N**

   OTHER: ____

2. Do you take Asprin, Plavix, Coumadin, Pradaxa or other blood thinners? **Y/N** ______________
3. Do you need pre-medication before dental appointments? **Y/N** ______________________
4. Do you have any Artificial Joints? What? ____________________ When? ______________
5. Do you take Osteoporosis medications? **Y/N** Name: ___________________________
6. Do you take Viagra, Cialis or any other ED medications? **Y/N** ______________________
7. Current Medications: ____

   ____

8. LIST ANY CURRENT MEDICAL PROBLEMS: ___________________________________

Do you or have you ever had any of the following? Check **all** that apply:

MVP/Heart Murmur		High Blood Pressure		Respiratory Problems		Sickle Cell/Blood Disorder	
Cardiac Pacemaker		Low Blood pressure		Tuberculosis		Acid Reflux Disease	
Heart Attack/Disease When?__________		Seizures or Fainting		Thyroid Disorder		HIV/AIDS	
Stroke/ TIA'S When?__________		Hepatitis: A B or C		Kidney Disease		Eating Disorder	
Rheumatic fever		Liver Disease		Cancer Type? __________		Alcoholism/ Drug Addiction	
Diabetes: TYPE 1 2 Controlled? Y / N A1C Level? ________		Stomach pain/ulcers		Chemo/Radiation		Depression/ Psychiatric Disorder	

Do you use tobacco products? Smoke Dip Chew How often? ______________________

WOMEN

Are you pregnant? **Y / N** (____Weeks) Nursing? **Y / N** On birth control pills? **Y / N** On Hormone Replacement Therapy? **Y / N**

Reason for today's visit? ____

Date of last dental visit? ____

Consent:

I understand x-rays, models, and other diagnostic tools/test may be necessary to make a thorough diagnosis of the patient's dental needs, and authorize the Doctor to obtain and/or perform any and all diagnostic procedure necessary. I authorize the release of protected health information to parties involved in payment for services rendered. I understand payment in full, or co-insurance is due when serves are rendered, and I am responsible for all fees associated with my account regardless of insurance coverage.

______________________________ ______________________ ____________

Patient's Signature (Parent/Guardian if minor) Print name of Signatory Date

______________________________ Michelle A. Getz, DMD ____________

Doctor's Signature Date

FOR OFFICE USE:

DATE:		DATE:		DATE:	
BP:	PULSE:	BP:	PULSE:	BP:	PULSE: