Bastrop Dentures AND Implant Center

First Name: ______________________ MI ________ Last Name: ______________________

Date: _______/_______/_______ Age: _________ ☐ Female ☐ Male Birthdate: ____________________

Mailing Address: ____

City:______________________________ State:______________ Zip: ________________

Home # ____________________ Work # ____________________ Cell # ____________________

Email Address:____

Emergency Contact: ______________________________ Cell # ______________________

Physician Name: ______________________ Cardiologist Name: ______________________

Phone #: ______________________ Phone #: ______________________

DOCTOR USE ONLY

	Yes	No
Physician Consult Needed	☐	☐

Premedicate:

☐ At appointment ☐ 1 week before ☐ 1 week after

ASA _______

WOMEN:

	Yes	No
Are you pregnant/trying to get pregnant?	☐	☐
Are you taking oral contraceptives?	☐	☐
Are you nursing?	☐	☐

Mallampati: ______________ **Ht:** ______________ **Wt:** ______________ **BMI:** ______________

	Yes	No
Are you under a physicians care now?	☐	☐
Do you have any natural teeth?	☐	☐
Do you have any abnormal bleeding associated with previous surgery, dental extractions or accident?	☐	☐
Have you ever had any trouble associated with any previous dental care?	☐	☐
Have you ever been treated for any gum disease? (Gingivitis, Periodontitis, Piorrhea-Bleeding gums when brushing)	☐	☐
Do you grind or clinch teeth?	☐	☐
Do you have frequent sores in your mouth or jaws?	☐	☐
Do you have any swelling of the mouth or jaws?	☐	☐
Have you ever suffered injuries in your mouth or jaw?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐

Medical History Questions

	Yes	No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Have you had any prosthetic joints, knee, or hip replacements less than 2 years ago?	☐	☐
Do you have a prosthetic heart valve?	☐	☐
Have you had a previous history of bacterial endocarditis?	☐	☐
Do you have a pacemaker or defibrillator placed less than 6 weeks ago?	☐	☐
Have you had grafts or coronary artery bypass surgery less than 6 weeks ago?	☐	☐
Are you undergoing treatment for Renal Dialysis?	☐	☐
Have you had a recent AV shunt placed?	☐	☐
Do you have a history of systemic lupus? (Requires medical consult before dental treatment)	☐	☐
Have you ever had a premed with antibiotics prior to dental work?	☐	☐

Why? ____________________________________

Is there anything else you would like to tell us?	☐	☐

____

____

(SEE BACK PAGE ➦)

Do you have any of the following medical conditions?

Yes	No	Condition
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bisphosphonates
☐	☐	Blood Transfusion
☐	☐	Breathing Problems
☐	☐	Cancer Where? _________________________
☐	☐	Cardiac Pacemaker
☐	☐	Cholesterol
☐	☐	Congenital Heart Disease: Heart Surgery? ☐ Yes ☐ No Heart Attack? ☐ Yes ☐ No Stents? ☐ Yes ☐ No Pacemaker? ☐ Yes ☐ No Ablation? ☐ Yes ☐ No
☐	☐	COPD
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Dysphagia (difficulty swallowing)
☐	☐	Epilepsy / Seizures
☐	☐	Visually Impaired
☐	☐	Fainting Spells / Convulsions
☐	☐	Hearing Impaired / Disability
☐	☐	Heart Murmur
☐	☐	Hepatitis or Liver Disease
☐	☐	Hepatitis A, B, or C
☐	☐	High Blood Pressure
☐	☐	HIV / AIDS
☐	☐	Hives or Skin Rash
☐	☐	Joint Replacement Knee ____________ When ____________ Hip _____________ When ____________
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Liver Disease
☐	☐	Lupus
☐	☐	Lung Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Mental Health Disease
☐	☐	Osteoporosis
☐	☐	Parkinson’s Disease
☐	☐	Persistent Cough or Cough Up Blood
☐	☐	Pneumonia
☐	☐	**Pregnant**
☐	☐	Prolonged Bleeding / Hemophilia
☐	☐	Radiation / Chemotherapy
☐	☐	Rheumatic Fever
☐	☐	Sickle Cell Disease / Sickle Cell Trait
☐	☐	Sinus Trouble
☐	☐	Sleep Apnea
☐	☐	CPAP
☐	☐	Smoker
☐	☐	Stomach Ulcers
☐	☐	Stroke
☐	☐	Thyroid Disease
☐	☐	Tuberculosis
☐	☐	Other ________________________________

Are you taking any of the following medications?

Yes	No	Medication
☐	☐	Antibiotics Name: ________________________
☐	☐	Anticoagulants – If Yes, Please Circle Medication Type: Coumadin Lovenox Plavix Aggrenox Pradaxa Other: _________________
☐	☐	Aspirin
☐	☐	Cortisone or Steroids
☐	☐	Dilantin or other Anticonvulsant
☐	☐	Insulin, Tollbutamide, Orinase or Similar Drug: __________________________
☐	☐	High Blood Pressure Medicine
☐	☐	Tranquilizers

Have you ever had an adverse reaction/allergy to any of the following drugs?

Yes	No	Drug
☐	☐	Aspirin
☐	☐	Barbituates / Sedatives
☐	☐	Cephalexin
☐	☐	Clindamycin
☐	☐	Latex
☐	☐	Codeine
☐	☐	Local Anesthetics
☐	☐	Novocain
☐	☐	Penicillin
☐	☐	Sulfa Drugs
☐	☐	Any other reactions / allergies? ____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature: ______________________________________ Date: ___________________

Doctor’s Signature: _____________________________________ Date: ___________________