ADVANCED IMPLANT DENTISTRY

AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

MEDICAL HISTORY FORM **Date**

_____

Name_____ **Home Phone ( ) _____**
Last First Middle

Business Phone ( ) _____

Address _____

Cell Phone ( ) _____

City _____ **State** _____ **Zip Code** _____

Occupation _____ **Email Address**_____ **Social Security No.**_____

Date of Birth_____/_____/_____ **Sex M F Height** _____ **Weight** _____ **Single** _____ **Married** _____

Name of Spouse_____ **Closest Relative** _____ **Phone** _____

If you are completing this for another person, what is your relationship to that person? _____ **Your Phone Numbers** _____

Referred by _____ **Phone ( ) _____**

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?	**YES**	**NO**
2. Has there been any change in your general health within the past year?	**YES**	**NO**
3. My last physical examination was on		
4. Are you now under the care of a physician?	**YES**	**NO**
If so, what is the condition being treated?		
5. The name/address/phone of my physician(s) is		
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?	**YES**	**NO**
If so, what was the illness or problem?		
7. Are you taking any medicine(s) including non-prescription medicine(s)?	**YES**	**NO**
If so, what medicine(s) are you taking? (List medicines below):		
a. Are you taking Coumadin ?	**YES**	**NO**
b. Are you taking Plavix ?	**YES**	**NO**
c. Are you taking Aspirin ?	**YES**	**NO**
d. Are you taking Fosomax or have you ever taken Fosomax ?	**YES**	**NO**
e. Are you taking Actonel or have you ever taken Actonel ?	**YES**	**NO**
f. Are you taking Boniva or have you ever taken Boniva ?	**YES**	**NO**

ADVANCED IMPLANT DENTISTRY
AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

g. Are you taking Atelvia or have you ever taken Atelvia ?	YES	NO
h. Have you ever had an IV infusion of Zomata ?	YES	NO
i. Have you ever had an IV infusion of Aredia ?	YES	NO
j. Have you ever had an IV infusion of Reclast ?	YES	NO
k. Have you ever taken Prolia ?	YES	NO
8. Do you have or have you had any of the following diseases or problems?		
a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease	YES	NO
b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion,	YES	NO
high blood pressure, arteriosclerosis, stroke)	YES	NO
1. Do you have chest pain upon exertion?	YES	NO
2. Are you ever short of breath after mild exercise or when lying down?	YES	NO
3. Do your ankles swell?	YES	NO
4. Do you have inborn heart defects?	YES	NO
5. Do you have a cardiac pacemaker?	YES	NO
c. Allergy	YES	NO
d. Sinus trouble	YES	NO
e. Asthma or hay fever	YES	NO
f. Fainting spells or seizures	YES	NO
g. Persistent diarrhea or recent weight loss	YES	NO
h. Diabetes	YES	NO
i. Hepatitis, jaundice or liver disease	YES	NO
j. AIDS or HIV infection	YES	NO
k. Thyroid problems	YES	NO
l. Respiratory problems, emphysema, bronchitis, etc.	YES	NO
m. Arthritis or painful swollen joints	YES	NO
n. Stomach ulcer or hyperacidity	YES	NO
o. Kidney trouble	YES	NO
p. Tuberculosis	YES	NO
q. Persistent cough or cough that produces blood	YES	NO
r. Persistent swollen glands in neck	YES	NO
s. Low blood pressure	YES	NO
t. Sexually transmitted disease	YES	NO
u. Epilepsy or other neurological disease	YES	NO
v. Problems with mental health	YES	NO
w. Cancer	YES	NO
x. Problems of the immune system	YES	NO
9. Have you had abnormal bleeding?	YES	NO
a. Have you ever required a blood transfusion?	YES	NO

ADVANCED IMPLANT DENTISTRY

AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

10. Do you have any blood disorder such as anemia?	**YES**	**NO**
11. Have you ever had any treatment for a tumor or growth?	**YES**	**NO**
12. Are you allergic or have you had a reaction to	**YES**	**NO**
a. Local anesthetics	**YES**	**NO**
b. Penicillin or other antibiotics	**YES**	**NO**
c. Sulfa drugs	**YES**	**NO**
d. Barbiturates, sedatives, or sleeping pills	**YES**	**NO**
e. Aspirin	**YES**	**NO**
f. Iodine	**YES**	**NO**
g. Codeine or other narcotics	**YES**	**NO**
h. Other	**YES**	**NO**
13. Do you smoke?	**YES**	**NO**
a. What do you smoke?		
b. How much and how often?		
14. Have you had any serious trouble associated with any previous dental treatment?	**YES**	**NO**
If so, explain:		
15. Do you have any disease, condition, or problem not listed above that you think I should know about?	**YES**	**NO**
If so, explain		
16. Are you wearing contact lenses?	**YES**	**NO**
17. Are you wearing removable dental appliances?	**YES**	**NO**
***** THIS SECTION IS FOR WOMEN ONLY *****		
18. Are you pregnant?	**YES**	**NO**
19. Do you have any problems associated with your menstrual period?	**YES**	**NO**
20. Are you nursing?	**YES**	**NO**
21. Are you taking birth control pills?	**YES**	**NO**

Chief Dental Complaint:_____

_____

_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I made in the completion of this form.

ADVANCED IMPLANT DENTISTRY
AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

Signature of Patient: _____ **Date:** _____

CONSENT FOR ELECTRONIC TRANSMISSION OF DENTAL RECORDS AND INFORMATION

I, _____ authorize that my dental information can be emailed or electronically transmitted to a doctor that referred me, to a doctor that I am being referred to, or to a medical or dental insurance company.

I authorize that my dental information may be emailed or transmitted electronically within this office between doctors and staff members and between staff members.

This dental information may include my dental chart, progress notes, account ledger, xrays, CT scans, treatment letters, treatment plans, information pertinent to my treatment, or dental or medical insurance forms.

Signed By:

_____	_____	_____
Date	**Patient**	**Witness**

ADVANCED IMPLANT DENTISTRY

AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

Acknowledgment of Receipt of Notice of Privacy Policies And Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of the Patient or Personal Representative

Print Name of Patient or Personal Representative (including description of legal authority)

Date

ADVANCED IMPLANT DENTISTRY

AND ORAL RESTORATION

Michael Klein, D.D.S.
Allon Waltuch, D.D.S.

Pharmacy Information

Patient Name: _____

Date of Birth: _____

Home Address: _____

_____

Home Phone: _____

Cell Phone: _____

Name of Pharmacy: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

I understand that Advanced Implant Dentistry will be sending any prescriptions I may need to the above pharmacy based upon the details that
I have provided above. I will inform the office if there is any change in my pharmacy details.

Signature: _____

Date:_____