TYLER BAKER, DMD

Patient Name _____ Date of Birth _____ Date _____

PATIENT MEDICAL HISTORY

Are you allergic to Penicillin? ❑Y ❑ N

Do you have any allergies? _____

Do you have, or have you had and of the following:

❑Y ❑ N	Artificial Heart Valve _____Date Placed	❑Y ❑ N	Pacemaker	❑Y ❑ N	Tuberculosis
❑Y ❑ N	Joint Replacement _____ Year Placed	❑Y ❑ N	Hemophilia	❑Y ❑ N	Heart Stent _____ Date Placed
❑Y ❑ N	Heart Shunt or Conduit	❑Y ❑ N	COPD	❑Y ❑ N	Mitral Valve Prolapse
❑Y ❑ N	Cancer _____ Type	❑Y ❑ N	Leaky Valve	❑Y ❑ N	Hepatitis A / B / C
❑Y ❑ N	Low Blood Pressure	❑Y ❑ N	AIDS / HIV	❑Y ❑ N	High Blood Pressure
❑Y ❑ N	Congenital Heart Disease	❑Y ❑ N	Rheumatic Fever	❑Y ❑ N	Endocarditis
❑Y ❑ N	Radiation/Chemotherapy	❑Y ❑ N	Diabetes	❑Y ❑ N	Epilepsy / Seizures
❑Y ❑ N	Chronic Sinus Problems	❑Y ❑ N	Allergic to Latex	❑Y ❑ N	Metals

Medical History Summary Please list any additional medical history information for the Doctor

_____

_____

_____

Do you take or have you ever taken any of the following BISPHOSPHONATES for osteoporosis?

❑Y ❑ N	Fosamax	❑Y ❑ N	Didronel	❑Y ❑ N	Boniva	❑Y ❑ N	Skelid
❑Y ❑ N	Binisto	❑Y ❑ N	Reclast	❑Y ❑ N	Atelvia	❑Y ❑ N	Zometa
❑Y ❑ N	Fen-Phen	❑Y ❑ N	Prolia	❑Y ❑ N	Aredia	❑Y ❑ N	Actonel

If you answered Yes to any of the above, how long did you take the medication? _____

LIST ALL Medications you take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you Pregnant? ❑Y ❑ N Anticipated due date: _____

I have read the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist to determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the Dentist or office staff. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature in all insurance forms. I authorize the dentist to release all information necessary to secure the payment of benefits.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I UNDERSTAND THAT ANY ESTIMATES / TREATMENT PLANS GIVEN TO ME ARE ONLY AN ESTIMATE OF SERVICES AND INSURANCE COVERAGE AND NO GUARENTEE OF INSURANCE PAYMENT IS MADE OR ASSUMED. I UNDERSTAND THAT PAYMENT IN FULL IS DUE THE DAY SERVICES ARE RENDERED.

I hereby authorize the release of any and all medical and dental records to Tyler Baker, DMD, LLC

_____ _____

Patient / Responsible Party Signature Date