MEDICAL FORM

Wendy Bach, DDS, PA

PATIENT NAME: _____ BIRTH DATE: _____ CALENDAR YEAR: _____

Who would you have us call in an emergency?

NAME: _____ RELATION: _____ PHONE NUMBER (mobile or daytime): _____

LIST ALL MEDICATIONS YOU TAKE (BOTH PRESCRIPTION AND OVER THE COUNTER):

Do you have or have you ever had any of the following?

- ☐ Heart Condition
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Pacemaker Insertion
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ High OR Low Blood Pressure
- ☐ Diabetes
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Chemotherapy / Radiation
- ☐ Glaucoma
- ☐ Artificial Joint
- ☐ Hemophilia / Bleeding Disorder
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Fever Blisters / Cold Sores
- ☐ Shingles
- ☐ Hepatitis / Jaundice
- ☐ Kidney Problems
- ☐ Ulcers
- ☐ Stroke
- ☐ Fainting
- ☐ Sinus Trouble
- ☐ Frequent Headache / Migraines
- ☐ Colitis
- ☐ Mental Health Issues
- ☐ Drug / Alcohol Dependence
- ☐ Sexually Transmitted Disease
- ☐ HIV / AIDS

Are you allergic to or have difficulty with any of the following substances?

- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Dental Anesthetics
- ☐ Metal

Other Medications:

Do you exercise regularly?

◉ Yes ○ No

If yes, what do you enjoy doing?

Do you have a history of or are you currently using tobacco or e-smoke products?

○ Yes ◉ No

If yes, for how long?

If you have quit, for how long?

Are you taking birth control pills?

◉ Yes ○ No

Are you pregnant? ◉ Yes ○ No

If yes, due date?

Are you nursing? ○ Yes ○ No

The information presented on this page is true to the best of my knowledge. The undersigned authorized the doctor to take x-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perforany and all forms of treatment, medication, and therapy which may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made. In the event of a default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNATURE: _____ DATE: _____