

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

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

Penicillin	Tetracycline	Latex	Other Medications:
Aspirin	Codeine	Dental Anesthetics	
Sulfa	Erythromycin	Metal	

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 perform any 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: