Central New England
endodontics & implantology

Welcome to Our Office!

In order to serve you promptly we will need the following information.
All information will be strictly confidential.

NAME: _____ Date of Birth _____

Who is your medical Doctor? _____ What is your occupation? _____

MEDICAL HISTORY: Do you have or have you had any of the following?

Yes	No	Heart Attack	Yes	No	Hepatitis A, B or C
Yes	No	Rheumatic Fever	Yes	No	Low Blood Pressure
Yes	No	Mitral Valve Prolapse	Yes	No	Epilepsy/Convulsion
Yes	No	AIDS or HIV Positive	Yes	No	High Blood Pressure
Yes	No	Clotting or Bleeding Problems	Yes	No	Kidney Disease
Yes	No	Respiratory Problems	Yes	No	Fainting
Yes	No	Thyroid Problems	Yes	No	Tuberculosis
Yes	No	Heart Disease	Yes	No	Asthma
Yes	No	Stroke	Yes	No	Sinusitis
Yes	No	Cardiac Pacemaker	Yes	No	Cancer
Yes	No	Heart Murmur	Yes	No	Diabetes
Yes	No	Joint Replacement	Yes	No	Arthritis
Yes	No	Liver Disease	Yes	No	Other _____
Yes	No	Emphysema	Yes	No	Do you smoke?

Yes No Any other diseases or medical problems? _____
Yes No Do you need to be pre-medicated with antibiotics for dental visits?
Yes No Are you currently being treated by another dental specialist? _____
Yes No Are you allergic to any antibiotics, pain medications or latex rubber? _____
Yes No Are you allergic to any other medicines, drugs, food, or other? _____
Yes No In the past, have you taken the weight loss medications "Redux", fenfluramine or dexfenfluramine?
Yes No If yes, have you consulted with your physician or cardiologist?
Yes No If yes, has he/she told you NOT to pre-medicate?
Yes No Are you taking bisphosphonates like FOSAMAX or other medication for osteoporosis?

What medications are you currently taking? (Including pain medications, vitamins, etc.) _____

_____

Women: Are you pregnant? Yes _____ No _____ Possibly _____ If yes, what trimester? _____
Do you take birth control pills? Yes _____ No _____

The information given above is true to the best of my knowledge. I will inform the dentist of any change in my health and/or medication.

_____ _____
Name *Date*

Who can we thank for your referral to our office? _____
Name of doctor who should receive the report of your treatment here _____

How did you hear about our office?

- ☐ *My general dentist*
- ☐ *Co-worker*
- ☐ *Other Source* _____
- ☐ *Friend or family*
- ☐ *Phone book*
- ☐ *CNEEI Website*
- ☐ *Billboard*
- ☐ *Insurance Company*