Q DENTAL GROUP

MEDICAL ALERT

Name: _____ (last) (first)

Spouse: _____

Parent (if child): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____

Cell _____

Where do you work: _____

Child lives with: both parents _____ mother _____ father _____

Patient date of birth: _____

Social Security #: _____

Date of last medical physical: _____

Physician name & phone#: _____

In case of emergency, notify: _____

How did you hear about us: _____

Your E-Mail: _____

## HEALTH INFORMATION

| Are you in good health? | Yes | No |
|---|---|---|
| DO YOU HAVE A HISTORY OF: | | |
| 1. Rheumatic fever | ☐ | ☐ |
| 2. Heart Murmur | ☐ | ☐ |
| 3. Heart trouble | ☐ | ☐ |
| 4. Heart Valve Disorder | ☐ | ☐ |
| 5. Mitral Valve Prolapse | ☐ | ☐ |
| 6. Heart Surgery (Bypass) | ☐ | ☐ |
| 7. Pacemaker | ☐ | ☐ |
| 8. ____ High or ___LOW Blood Pressure | ☐ | ☐ |
| 9. Blood Disease | ☐ | ☐ |
| 10. Liver Disease | ☐ | ☐ |
| 11. Kidney Disease | ☐ | ☐ |
| 12. Lung Disease | ☐ | ☐ |
| 13. Asthma | ☐ | ☐ |
| 14. Tuberculosis | ☐ | ☐ |
| 15. Sinus Problem | ☐ | ☐ |
| 16. Diabetes | ☐ | ☐ |
| 17. Artificial Joints | ☐ | ☐ |
| 18. Artificial Heart Valves | ☐ | ☐ |
| 19. Metal Implants, Screws or Plates | ☐ | ☐ |
| 20. HIV + or AIDS | ☐ | ☐ |
| 21. Hepatitis | ☐ | ☐ |
| 22. Epilepsy | ☐ | ☐ |
| 23. Cancer (Radiation Treatment) | ☐ | ☐ |
| 24. Venereal Disease | ☐ | ☐ |
| 25. Arthritis | ☐ | ☐ |
| 26. Organ Transplant | ☐ | ☐ |
| 27. Fainting or Dizziness | ☐ | ☐ |
| 28. Are you Pregnant | ☐ | ☐ |
| 29. Are you Nursing | ☐ | ☐ |
| 30. Are you taking Aspirin | ☐ | ☐ |
| 31. Are you taking Blood Thinners | ☐ | ☐ |
| 32. Thyroid Disease (Goiter) | ☐ | ☐ |
| 33. Are you taking or have you ever taken Bisphosphonates for Osteoporosis, (Fosamax, Actonel, Boniva). | ☐ | ☐ |

List any Medications you are taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you Allergic to any Medication:

1. _____
2. _____
3. _____

Date of Last Dental Visit _____

Reason for Dental Visit _____

Date of Last Routine Cleaning & Exam _____

Date of Last dental Xrays _____

If Wearing Full or Partial Dentures, Age of Dentures _____

Latex or Rubber Products Allergies _____

Do you have any other disease, condition or problem not listed above _____

## DENTAL INSURANCE INFORMATION

Primary Carrier _____

Subscriber _____

ID# _____ Grp# _____

P _____ B _____ M _____

Ded _____ Max _____

Insurance Limit _____

Secondary Carrier _____

Subscriber _____

ID# _____ Grp# _____

P _____ B _____ M _____

Ded _____ Max _____

Insurance Limit _____

Signature Patient or Parent _____ Reviewed By _____

Date _____