Paul Binon dds.msd
and associates IMPLANT DENTISTRY & PROSTHODONTICS

MEDICAL HISTORY

Patient Name: **Date of Birth:** **Date:**

Email: **Cell phone:**

Emergency Contact:_____Relationship: _____Phone: _____

Are you currently under the care of a physician for any illness or health problem? **YES** **NO**

Date of last visit:_____Reason for last visit:_____

Physician 1:_____Phone: _____Specialty:_____
Physician 2:_____Phone: _____Specialty:_____

Are you required to take any antibiotics prior to treatment ..... **YES** **NO**
Do you have any allergies or adverse side effects to any medications? If "YES" Please Explain: ..... **YES** **NO**

_____

_____

Please list any medications you are currently taking and for what reasons.

_____ _____ _____
_____ _____ _____

Do you have, or have you had any of the following health conditions? (Please provide information to all YES answers)

Rheumatic Fever, Scarlet Fever, Rheumatic or Congenital Heart Disease, Heart Murmur, Mitral-Valve Prolapse ..... **YES** **NO**
Heart Trouble, Heart Attack, Angina, Pacemaker..... **YES** **NO**
Artificial Limb/Joint, Heart Valve..... **YES** **NO**
Stroke, Fainting Spells, Seizures/..... **YES** **NO**
High/Low Blood Pressure..... **YES** **NO**
Respiratory Lung Disorders, Tuberculosis, Asthma, Emphysema, Etc. ..... **YES** **NO**
Diabetes (self or family history) ..... **YES** **NO**
Restricted Diet of ANY kind..... **YES** **NO**
Cancer, Tumors..... **YES** **NO**
Kidney Trouble..... **YES** **NO**
Hepatitis, Jaundice, Liver Disease..... **YES** **NO**
Stomach/Intestinal Problems..... **YES** **NO**
Arthritis/Rheumatism..... **YES** **NO**
Glaucoma/Cataracts..... **YES** **NO**
Excessive Bleeding, Bruising or Anemia..... **YES** **NO**
Cold Sores, Herpes, Syphilis or Gonorrhea..... **YES** **NO**
HIV/AIDS/AIDS Related Complex..... **YES** **NO**

(*See reverse for continued health history information)*

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Psychiatric Care	**YES**	**NO**
Do you have a history of drug or alcohol abuse?	**YES**	**NO**
Do you smoke?	**YES**	**NO**
If you are a woman, are you pregnant or planning pregnancy?	**YES**	**NO**
Does your health restrict your physical activity in any way?	**YES**	**NO**
Are you taking ANY medications, prescriptions, and/or over-the-counter, (Including Fosamax, Aspirin, vitamins, Meridia, hormones, birth control pills, diet pills?	**YES**	**NO**
Have you ever taken Fen-Phen?	**YES**	**NO**
Do you have any disease/condition/handicap not listed above?	**YES**	**NO**

List Major Surgeries/Hospitalizations: _____

_____

To assist us with your dental needs/concerns, please answer the following questions.

Are any of your teeth sensitive to heat, cold or pressure?	**YES**	**NO**
Do any of your teeth ache?	**YES**	**NO**
Do you grind your teeth or clench your jaw?	**YES**	**NO**
Do you have a clicking in the jaw joint or around your ear?	**YES**	**NO**
Do you have difficulty opening your mouth wide?	**YES**	**NO**
Have you ever had braces (orthodontics)? If "yes" how long ago?	**YES**	**NO**
Do you have difficulty swallowing or dry mouth?	**YES**	**NO**
Are there any sores or growths in your mouth?	**YES**	**NO**
Are you dissatisfied with the appearance of your teeth?	**YES**	**NO**

Do you have any other dental concerns? _____

_____

_____

Please note, a change in your health status should be reported to the office at the earliest possible time

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Thank you for taking the time to fill out this form completely and accurately. Incorrect information can be dangerous to your health. Your complete comfort and satisfaction are our primary concern. To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to Dr. Binon's office to release health information obtained from me, and information about my dental treatment to third party payors and/or other health practitioners.

Print Name _____

Is patient a minor? **YES** **NO**

Patient (or guardian) Signature _____ Date _____

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