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Medical Alert	
PREMED	ALLERGIES
ANESTHETIC	LATEX

### Client Information – History Form

In order to serve you properly, we need the following information. All information is strictly confidential.

Today's date: \_\_\_\_\_ Purpose of appointment: \_\_\_\_\_  
 Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 If a minor, parent/guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home address: \_\_\_\_\_  
 Employer name: \_\_\_\_\_ Employer address: \_\_\_\_\_  
 Marital status: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Name and phone # of someone we may contact in an emergency: \_\_\_\_\_  
 Who may we thank for referring you to us? \_\_\_\_\_

**(The policy of this office does not permit parents in the dental operatory with their children during dental procedures.)**

### Patient Dental and Medical History

Name of previous dentist: \_\_\_\_\_ Address: \_\_\_\_\_  
 Date of last exam: \_\_\_\_\_ Do you need to be premedicated for dental procedures? YES NO  
 Are you in good health? YES NO Date of last health exam: \_\_\_\_\_  
 Are you currently in the care of a physician? YES NO If yes, for what? \_\_\_\_\_  
 Name of physician: \_\_\_\_\_ Physician's phone # \_\_\_\_\_  
 Are you taking any prescription or over-the-counter medications? YES NO If yes, please list the drug names, why you are taking them, and the dose: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Do you take any natural products (including herbs) or vitamins? YES NO

If yes, please list: \_\_\_\_\_

Have you ever been treated for substance abuse? YES NO Do you consume alcohol? YES NO

Do you smoke or chew? YES NO Have you been hospitalized for any surgical operation or serious illness? YES NO

If yes, please explain: \_\_\_\_\_

**WOMEN ONLY:** Are you pregnant or think you might be pregnant? YES NO If yes, expected due date: \_\_\_\_\_

Are you nursing? YES NO Do you take oral contraceptives YES NO Name of OB/GYN: \_\_\_\_\_

#### Allergies: Are you allergic to or have you had a reaction to:

(CIRCLE ONE)

YES NO LOCAL ANESTHETICS

YES NO ASPIRIN

YES NO SULFA DRUGS

YES NO ANY METAL (NICKEL, GOLD, ETC.)

YES NO LATEX

YES NO BARBITUATES, SEDATIVES OR SLEEPING PILLS

YES NO CODEINE OR OTHER NARCOTICS

YES NO PENICILLIN OR OTHER ANTIBIOTICS – PLEASE LIST \_\_\_\_\_

YES NO OTHER – PLEASE LIST \_\_\_\_\_

**Client Health History** – Do you have, or have you had the following? (Circle one)

YES NO	Arthritis	YES NO	HIV/AIDS	YES NO	Artificial joint
	Type: _____	YES NO	Low blood pressure		Date: _____
YES NO	Asthma	YES NO	Pacemaker	YES NO	Dental Implants
YES NO	Blood transfusion	YES NO	Diabetes		Date: _____
	If yes, date: _____		Type: _____	YES NO	Neurological disorders
YES NO	Bleeding problems	YES NO	Dry mouth	YES NO	Osteoporosis
YES NO	Hemophilia	YES NO	Epilepsy	YES NO	Respiratory problems
YES NO	Cancer	YES NO	Fainting spells	YES NO	TB
YES NO	Leukemia	YES NO	Seizures		Date: _____
YES NO	Chemotherapy	YES NO	G.I. Reflux	YES NO	Severe headaches
YES NO	Radiation	YES NO	Hepatitis	YES NO	Sexually transmitted disease
YES NO	Heart trouble		Type: _____	YES NO	Sinus trouble
YES NO	Heart murmur	YES NO	Kidney problems	YES NO	Sores in the mouth
YES NO	Angina	YES NO	Lupus Erythematosis	YES NO	Ulcers in the mouth
YES NO	Artificial heart valve	YES NO	Mental health disorders	YES NO	Stroke
YES NO	Damaged heart valve	YES NO	Liver problems	YES NO	Thyroid problems
YES NO	Heart attack	YES NO	Diarrhea (chronic)	YES NO	Ulcers
YES NO	High blood pressure	YES NO	Fibromyalgia	YES NO	Anemia

If yes to any of the above, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand it is my responsibility to inform the dentist of any changes in my medical status. I will not hold my dentist or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the treatment of such dental care to third party payers and/or health practitioners. I acknowledge it is the policy of the dental office not to permit parents in the dental operator with their children during dental procedures. I understand that I will be charged for no-show appointments or chronic cancellations, and that I must give 48 hours notice when canceling an appointment. If less than 48 hours cancellation notice a \$50 per treatment hour fee will be charged. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment. I also understand that blood tests may be performed upon me if a health worker is exposed to my blood or other bodily fluids under his/her skin, in an open wound, or through a mucous membrane while treating me at this facility. I have been informed that this procedure will be discussed with me prior to its taking place. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

\_\_\_\_\_  
 Date: \_\_\_\_\_

Signature of patient or legal guardian. This form MUST be signed by a person of legal age.

Dentist's comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient goals for treatment: \_\_\_\_\_

Patient's blood pressure: \_\_\_\_\_ Date: \_\_\_\_\_ Dentist's signature: \_\_\_\_\_