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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 and relationship to patient: _____ 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 operator 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?(circle one) YES NO
 Are you in good health?(circle one): YES NO Date of last health exam: _____
 Are you currently in the care of a physician? (circle one) 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)

Form with columns for YES/NO and conditions: Arthritis, HIV/AIDS, Artificial joint, Asthma, Low blood pressure, Dental Implants, Blood transfusion, Diabetes, Neurological disorders, Bleeding problems, Dry mouth, Osteoporosis, Hemophilia, Epilepsy, Respiratory problems, Cancer, Fainting spells, TB, Leukemia, Seizures, Chemotherapy, G.I. Reflux, Radiation, Hepatitis, Heart trouble, Kidney problems, Heart murmur, Lupus Erythematosus, Angina, Mental health disorders, Artificial heart valve, Liver problems, Damaged heart valve, Diarrhea (chronic), Heart attack, Fibromyalgia, High blood pressure, 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 operatory 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.

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

Dentist's comments: _____

Patient goals for treatment: _____

Patient's blood pressure: _____ Date: _____ Dentist's signature: _____