DRS. P.H. TRESTER, H. TONY DAVID, A. SADEGHI

Patient's Name _____ Today's Date _____

Phone (H) _____ Phone (W) _____ Phone (cell) _____

Address_____ City _____ Postal code_____

Date of Birth (mdy) _____ Age:_____ Weight_____ Male _____ Female _____

E-mail _____Alternate contact_____

Your Medical Doctor is _____ Phone # _____

Medical Insurance (care card) _____

Who referred you to our office? _____

Your Dentist is _____ **Phone #** _____

What kind of treatment were you referred for _____

HAVE ANY OF THE FOLLOWING MEDICAL/DENTAL CONDITIONS EVER AFFECTED YOU? (circle Y yes or N no)

Y N Any previous medical or oral surgery (If yes, explain)_____

Y N Any Anesthetic problems relating to any surgery (If yes, explain)_____

Y N Any heart problems or heart murmur (if yes, explain)_____

Y N Have you ever tested positive for HIV, Hepatitis A, B, C, (if yes when) _____

Y N Diabetes (how is it treated) _____

Y N TMJ (jaw) problems (if yes, explain) _____

Y N Do you take blood thinners (aspirin or Coumadin /Warfarin etc.)

Y N Do you take medication for Osteoporosis (e.g. Fosamax, etc.)

Y N Any Stomach or intestinal disorders _____

Y N **ANY DRUG ALLERGIES (list)** _____

Y N **ANY** food, or environment allergies (list)_____

Y N Asthma		**Y N** T.B.
Y N Smoker	**Y N** Shortness of Breath	**Y N** Cancer
Y N Rheumatic Fever	**Y N** Glaucoma	**Y N** High Blood Pressure
Y N Convulsive Seizures	**Y N** Bleeding Problems	**Other** _____

Y N Are you now taking **ANY** drugs or medications (if yes what are they): _____

_____

Women: **Y N** Are you pregnant or is there a possibility you might be pregnant?

Y N Are you taking birth control pills?

Y N **Do you have any medical/dental condition or drug use that you wish to discuss in private?**

I hereby certify the above history to be correct (your signature) _____

First Dental Insurance Carrier _____Coverage % _____

Policy# _____ ID # _____ Dependant # ____ Limit _____

Dental Insurance Plan Holder: self or (name)_____ Birth date_____

Second Dental Insurance Carrier_____Coverage % _____

Policy# _____ ID # _____ Dependant # ____ Limit _____

Dental Insurance Plan Holder: self or (name) _____ Birth date_____

Guardian _____ Phone # _____