Medical Information

Patient Name:_____ Date:_____

Emergency Contact Name and Number: _____

DO YOU SMOKE? _____ HOW MUCH?_____

Please attach a list of daily medications with dosage and conditions to this form or list medications and conditions below. Bring this list with you to your scheduled appointment

_____

_____

_____

_____

DO YOU HAVE ANY JOINT REPLACEMENTS? _____

If yes, what was the date of your surgery? _____

DO YOU PREMEDICATE FOR DENTAL APPOINTMENTS? _____

If yes, with what medication? _____

DO YOU CLENCH OR GRIND YOUR TEETH? _____

If yes, do you wear a night guard appliance? _____

ARE YOU A DIABETIC? Y____ N____ If Yes - Prediabetes Type 1 Type 2

Medication:_____

Last A1C Level:_____ Date of Blood work: _____

Provider who manages your Diabetes Name and Number:_____

ARE YOU BEING TREATED FOR OSTEOPOROSIS/OSTEOPENIA? _____

Medication:_____

Date of last injection (if applicable) _____ Date of next injection _____

Do you have an allergy to IODINE or SHELL FISH? _____

Please list any Allergies or Uncomfortable reactions to medications, food or products:

_____

_____