Dentist ADK

Medical History

Bard J. Levey D.D.S., PLLC

Date: _____

Name: _____ DOB: _____

Address: _____

_____

_____

E-mail: _____ Phone#: _____ ☐ Cell ☐ Home

Emergency, Contact & Phone: _____

Physician: _____ Phone#: _____

Pharmacy: _____ Phone#: _____

Whom may we thank for referring, how did you hear about our office _____

Medical Conditions: Please check all that apply

- ☐ Asthma
- ☐ Artificial Joints (R/L Hip/Knee)
- ☐ Diabetes
- ☐ Allergies to medication/Latex
- ☐ Prosthetic Artificial Heart Valve
- ☐ Liver or kidney disease
- ☐ Respiratory Disease (COPD)
- ☐ Mitral Valve Prolapse/Murmur
- ☐ Bleeding Disorders/Blood Thinners
- ☐ Chest Pain
- ☐ Pacemaker
- ☐ Thyroid Disease (Hyper/Hypo)
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Stroke
- ☐ Ulcers
- ☐ HIV/AIDS
- ☐ Fainting/ Seizures
- ☐ Steroid Use.
- ☐ Psychiatric Therapy
- ☐ Stomach Issues
- ☐ Cold Sores
- ☐ Hepatitis/ Jaundice
- ☐ Cancer (Chemo/Radiation)
- ☐ Blood Pressure (High/Low) _____

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Women are you: ☐ Pregnant ☐ Nursing Taking Birth Control ☐ Yes ☐ No

Please explain any Medical Conditions as needed:

_____

_____

_____

_____

_____

Allergies: Please check if you have had an **adverse reaction** or have been told **NOT** to use any of the following:

☐ Latex ☐ Codeine ☐ Aspirin ☐ Ibuprofen ☐ Acetaminophen ☐ Local Anesthetic ☐ Sulfa

Other:_____

Please list your **prescription medications** and explain what condition you take it for:

_____

_____

_____

_____

_____

- **Have you ever used bisphosphonate medication? (common drug names Fosamax, Actonel, Atelvia, Didronel, Boniva) ☐ Yes ☐ No**

- Tobacco Use ☐ Yes ☐ No How much per day _____ for how long _____
- Do you snore? ☐ Yes ☐ No
- Do you feel well rested in the morning? ☐ Yes ☐ No
- Have you ever had your Vitamin D level checked? ☐ Yes ☐ No
- Is there anything you would like to change about your Smile/Teeth ☐ Yes ☐ No
- If yes, please explain: _____

  _____
- Anxiety level regarding dentistry: ☐ None ☐ Low ☐ Medium ☐ High

Consent for Treatment:

To the best of my knowledge, all answers are correct. I will notify Dr Levey if any changes in my health or medication should occur. I consent to the necessary treatment being performed on me by Dr. Levy and his staff, and to the use of photos for education and commercial purposes. Also, I understand the administration of local anesthetic may cause untoward reaction or side effects, which may include but are not limited to bruising, hematoma: cardiac stimulation temporary or rarely, permanent numbness; or muscle soreness. I understand that occasionally needles may break and require surgical retrieval.

Signature:_____ Date:_____