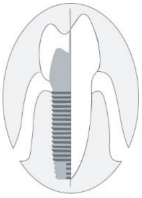

Clyde Robinson, D.D.S, M.Sc.D & Clark Mackelprang, D.D.S., M.S.

Tucson Dental Implants & Periodontics

Medical History Information

PATIENT INFORMATION…

Name: ____ Nickname: _______________________

Sex: ____ Birthdate: __________ Age: ______ Soc. Sec #: ______________ Email:_______________________

Street:_______________________________ Apt: ______ City: ______________ State: ______ Zip:________

Home Tel: ________________ Cell #: __________________ Have you been a patient of our practice? ______

Referred by: ____________________________ Has a family member been a patient of our practice? _______

Dentist:_________________________________ Medical Doctor: ________________________________

Employer : ___________________________________ Business Tel: ________________________________

Emergency Contact: _________________________ Tel: _________________ Relation: ________________

DENTAL INFORMATION…

Reason for today's visit: ____

____

Are you in pain? __________ For how long: ____

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters/sores in or around mouth
- ☐ Food caught between teeth
- ☐ Prolonged bleeding from an injury/extraction
- ☐ Lost/Broken filling(s)
- ☐ Teeth grinding/ clenching
- ☐ Ringing in ears
- ☐ Burning tongue/lips
- ☐ Gum Disease
- ☐ Stained Teeth
- ☐ Locking Jaw
- ☐ Bad Breath
- ☐ Toothache
- ☐ Missing teeth
- ☐ Difficulty opening or closing jaw
- ☐ Loose/ shifting teeth
- ☐ Broken/ chipped tooth
- ☐ Swelling/lumps in mouth
- ☐ Recent infections or sore throat

My teeth are sensitive to:

☐ Hot ☐ Cold

☐ Sweets ☐ Biting

Times a day you brush: _______________________

Times a week you floss: _______________________

What type of toothbrush bristles do you use: ☐ Soft ☐ Medium ☐ Hard

www.gumsandimplants.com
2330 North Rosemont Tucson, AZ 85712
Phone: 520.327.0263 ◦ Fax: 520.327.0965

MEDICAL HISTORY…

Have you ever been instructed to take antibiotics prior to dental procedures: ______________________________

Are you in good health? _____ Height: _______ Weight: ______ Are you under the care of a physician? _______

Have you had any illness, operation, or been hospitalized in the past five years? ___________________________

Do you have, or have you had, any of the following diseases, medical conditions, or procedures:

- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Infectious Mononucleosis
- ☐ Contagious diseases
- ☐ Delayed Healing (Tooth extractions)
- ☐ Tumor
- ☐ Blood disorder
- ☐ History of Alcohol abuse
- ☐ Eye Disease/Glaucoma
- ☐ Asthma
- ☐ Heart Surgery/ Prosthetic heart valve
- ☐ Are you immunosuppressed? (Possibly from transplant surg.)
- ☐ Hay fever / Sinus Problems
- ☐ Osteoporosis / Osteopenia
- ☐ Osteonecrosis
- ☐ Stomach Ulcers
- ☐ Heart attack(s)
- ☐ Irregular heart beat
- ☐ Cardiac pacemaker
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ History of Drug abuse
- ☐ Artificial knew or hip joint
- ☐ Bleeding tendency
- ☐ Problems w/immune system? (Possibly from med/surg.)
- ☐ Jaundice / Liver disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest pain / Angina
- ☐ Emphysema
- ☐ Do you smoke?
- ☐ Do you use chewing tobacco?
- ☐ Thyroid trouble
- ☐ Are you on a diet?
- ☐ Swollen Ankles
- ☐ Damaged heart valves
- ☐ Kidney Trouble
- ☐ Are you on dialysis?
- ☐ Arthritis / Joint disease
- ☐ Snoring / Sleep Apnea
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Fainting Spells
- ☐ Anemia
- ☐ Stroke
- ☐ Cancer/Radiation/Chemotherapy
- ☐ Bruise easily
- ☐ Abnormal bleeding
- ☐ HIV/AIDS

MEDICATIONS & ALLERGIES…

Are you taking, or have you ever taken:

☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Tranquilizers ☐ Insulin ☐ Antidepressants

☐ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

☐ Blood Thinners (Coumadin, Aspirin, Advil, Plavix, Xarelto, Pradaxa, Eliquis)

Please list any other medication(s) you are taking (including natural, herbal or homeopathic products):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Are you allergic to, or had a reaction to:

☐ Penicillin / Amoxicillin ☐ Local Anesthetic (numbing med) ☐ Valium or other tranquilizers ☐ Aspirin

☐ Codeine or other narcotics ☐ Latex ☐ Sulfites ☐ I have no known allergies.

Please list any other medication or antibiotic you are allergic to:	Please list any other allergies other than drug allergies:

1-4 BELOW FOR WOMEN ONLY

(Note: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your Physician/gynecologist for assistance regarding additional methods of birth control.)

1. Is there a possibility of pregnancy? ____
2. Expected delivery date: ____
3. Are you nursing? ____
4. Are you taking birth control pills? ____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I have made in the questionnaire above.

X_________________________________ X _________________________________ X __________________________
Signature of patient (Parent or guardian if Minor) Reviewed by Date

AUTHORIZATION & CONSENT

I authorize the office of Dr. Robinson and Dr. Mackelprang to release any information including the diagnosis and records of treatment of examination for myself and my dependent(s) to third party insurance carriers, payors, and/or health-care payor's practitioners.

I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This dental office cannot render services on the assumption that our fees will be paid by an insurance company.

As a courtesy, we will electronically file your insurance claims and have your insurance company reimburse you directly.

I have read the above conditions of treatment and payment and agrees to their content.

X ______________________________ **X** ______________________________
Signature of patient (Parent or guardian if minor) Date

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________ **X** ______________________________
Signature of patient (Parent or guardian if minor) Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ______________________________ **X** ______________________________
Signature of patient (Parent or guardian if minor) Date