Colonial Dental Group, Ltd.

David L. Dooley, D.D.S. **David B. Lewis, Jr., D.D.S.** **Alexander Quezada, D.D.S.**

The following is confidential information for our records only.

DATE: ____/____/____ BIRTHDATE: ____/____/____

PATIENT'S NAME: ____

(circle one: Mr. Mrs. Ms. Miss Dr. Other____________)

ARE YOU: SINGLE? MARRIED? WIDOWED? DIVORCED?

SPOUSE'S NAME/PARENTS' NAME (if applicable) ______________________________

HOW WOULD YOU PREFER TO BE ADDRESSED? ______________________________

(Ex: Mr. Jones, Robert, Bob, Dr. Jones)

ADDRESS: ____________________ CITY: ______________ ZIP: ________

PHONE: (Home) (______) ______-__________ (Business) (______) ______-__________ Ext: ________

FAX #: (______) ______-__________ CELL #: (______) ______-__________ EMAIL: ______________

EMPLOYER: __________________ OCCUPATION: ____________________

BUSINESS ADDRESS: ____

S.S. #: ________-______-__________ PERSON RESPONSIBLE FOR ACCOUNT:________________

PHONE NUMBER: ______________________________

PERSON TO NOTIFY IN CASE OF AN EMERGENCY: ______________________________

ADDRESS (if different from above): ______________________________

PHONE NUMBER: ______________________________

REFERRED TO US BY: __________________ PURPOSE OF VISIT: __________________

MEDICAL DR.'S NAME: ________________ DATE OF LAST PHYSICAL EXAM: ______________

ADDRESS: ____________________ PHONE: ____________________

MEDICAL HISTORY

List any medications that you are currently taking (prescription, non-prescription, herbal, natural products, or vitamins):

Medications	Quantity	Reason

1. Are you in good health at this time? .... Yes No
2. Women only: Are you pregnant? Yes No Maybe Taking Birth Control Pills? Yes No
3. Are you currently under medical treatment? .... Yes No

   Please Specify: ____
4. Has your physician ever advised you to be premedicated with antibiotics for dental procedures? Yes No

   If so, what type of premedication? ______________________________
5. Have you ever had any major operations? .... Yes No

   Please specify ____
6. Have you ever had a serious accident involving head injury? .... Yes No
7. Are you allergic to or have you had an adverse reaction to any known drug, medication or material? Yes No

   If so, please specify ____

8. Do you have, or have you ever had (circle):

			Comments
Heart Disease or Attack	Yes	No	
Irregular Heartbeat	Yes	No	
Heart Murmur	Yes	No	
Heart Valve Replacement	Yes	No	
Mitral Valve Prolapse	Yes	No	
Anemia	Yes	No	
Rheumatism or Arthritis	Yes	No	
Alcohol Dependency	Yes	No	
Drug Dependency	Yes	No	
Habit of Using Tobacco Products	Yes	No	
Sinus Trouble	Yes	No	
Pacemaker	Yes	No	
Bleeding Disorder/Problem	Yes	No	
Hepatitis	Yes	No	
Liver Disease	Yes	No	
AIDS	Yes	No	
HIV Positive	Yes	No	
Hip or Joint Replacement	Yes	No	
Rheumatic Fever	Yes	No	
Herpes	Yes	No	
Kidney Disease	Yes	No	
Diabetes	Yes	No	
Asthma	Yes	No	
Epilepsy	Yes	No	
High Blood Pressure	Yes	No	
Stomach/Intestinal Problems	Yes	No	
Nervous or Mental Disorder	Yes	No	
Respiratory Disease	Yes	No	
Tumors or Growths	Yes	No	
Cancer	Yes	No	
Any Blood Disease	Yes	No	
Allergies	Yes	No	

Please note any other diseases or conditions not mentioned above: ____________________

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9. When was your blood pressure last checked? ____________ Blood pressure reading: ______/______
10. Do you have a history of fainting? ………………………………………………………… Yes No
11. Have you experienced any complications with healing? ……………………………………….. Yes No
12. Have you ever taken or been given any medications (bisphosphonates) for Osteoporosis or bone disorders, such as Aredia, Zometa, Didronel, Actonel, Skelid, Fosamax, or Boniva?…………………… Yes No

______________________________ ______________________________

Patient's Signature Date Dentist's Signature Date

Medical History Update: I have reviewed my medical history and made the necessary changes or have noted "no changes"

Date	Additions or Changes	Patient	Dr./Hyg.