Carter Periodontics & Implant Dentistry

2283 Raleigh Court • Clarksville, TN 37043 • (931) 614–6603

Patient Medical History

Medical Physician:_____ Office #:(_____) _____ Date of Last Physical:_____

Address:_____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? if yes, explain, _____ Yes No

3. Are you taking any medication(s) including non-prescription medicine?
o Yes o No If yes, what medication(s) are you taking?_____
_____
_____
_____
_____
_____

4. Do you use tobacco? Yes No
5. Do you use any illegal drugs? Yes No
6. Are you wearing contact lenses? Yes No
7. Are you taking blood thinners? Yes No
8. Do you take aspirin daily? Yes No

10. Are you allergic to or have any reactions to the following:
o Local Anesthetics (e.g. Novocaine)
o Penicillin
o Other Antibiotics
o Sulfa Drugs
o Barbiturates
o Sedatives
o Iodine
o Codeine
o Any Metal (e.g. Nickel, Mercury, etc.)
o Latex Rubber
o Other (please list)_____

11. Women Only:
Are you pregnant, or think you may be? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

9. Do you have, or have you ever had, any of the following? (Check the box if it applies to you)

O Rheumatic Fever	O Bleeding/Clotting Disorder	O Epilepsy/Convulsions
O Rheumatic Heart Disease	O Sickle Cell Anemia	O Sexually Transmitted Disease
O Heart Murmur	O Leukemia	O Glaucoma (Wide or Narrow)
O Mitral Valve Prolapse	O AIDS/HIV Infection	O Stomach Trouble Disorders
O Artificial Heart Valves	O Hepatis/ Jaundice, What type:_____	O Thyroid Disorder
O Artificial Joints or Implants	O Liver Disease	O Arthritis
O Organ Transplant	O Diabetes, Insulin Dependent O Yes O No	Other:_____
O Heart Attack	O Kidney Disease	
O Stroke	O Low/High Blood Pressure	
O Cardiac Pacemaker	O Asthma	
O Heart Disease/Trouble	O Tuberculosis	
O Angina/Chest Pains	O Emphysema/COPD	
O Cancer/Radiation therapy	O Respiratory Disease	

Authorizations and Rrelease:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be financially responsible for payments for all services rendered at each appointment on my behalf to my dependents. In the event that my payment is not received within 90 days of its due date. I agree to pay all costs of collection, including, but not limited to reasonable attorney's fees.

X_____

Patient signature and/or financially responsible party (parent or guardian if a minor)