

**MEDICAL HISTORY**

Please fill out this form as completely as you can. You may submit the completed form online, print and bring to your next appointment or simply fax it to (303) 773-9518.

The information you provide is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental needs. Incorrect information can be dangerous to your health. If you have any questions, we would be glad to help you. We look forward to working with you in maintaining good dental health.

1. Have you been under the care of a medical doctor during the past two years?    Yes    No

    Name:

    Phone Number:

    Date of last visit:

    Reason for visit:

2. Please list all medications you are currently taking, the dosage and frequency with which you take it.

Medication Name	Dosage	Frequency	Medication	Dosage	Frequency

3. Are you allergic to any drug/medicine allergies?    Yes    No

    If yes, please list:

4. Have you taken any other drugs not listed above in the past 6 months?    Yes    No

    If yes, please list:

5. Have you taken oral bisphosphonates?    Yes    No

    If yes please mark all that apply:    Actonel    Boniva    Fosamax    Skelif    Didronel

    How long have you been taking bisphosphonates?

6. Are you currently taking over the counter medications/vitamins/herbal treatments?    Yes    No

    If yes, please list:

7. Are you allergic to any medication or substance?    Yes    No

    If yes, please list:

8. Have you ever taken medicine for weight loss (diet pills)?    Yes    No

    If yes, please list:

9 . Have you taken any of the following...?

Fen-Phen (Fenfluramine-Phenpermine)	Yes	No
Pondimen (Fenfluramine)	Yes	No
Redux (Dexfenfluramine)	Yes	No

    If yes to any of the above, did you have a medical exam for heart issues?    Yes    No

10. Have you been a patient in a hospital during the past five years?    Yes    No

    If yes, please list:

11. Have you had any serious illnesses or operations in the last five years?    Yes    No

    If yes, please list:

12. Have you ever had a blood transfusion?    Yes    No

    If yes, please explain:

13. Have you ever had a bad reaction to a local anesthesia?    Yes    No  
 If yes, please list:

14. Do you need antibiotic pre-medication before dental treatment?    Yes    No  
 If yes, please list:

15. Indicate which of the following you have had or have at present (check all that apply):

	(Yes)	(No)		(Yes)	(No)		(Yes)	(No)
Acid reflux disease			Diet (special/restricted)			Leukemia		
AIDS			Dizziness			Lung disease		
Alcohol dependency			Eating disorder			Mitral valve prolapse		
Allergies			Emphysema			Mouth injury		
Anaphylaxis			Epilepsy/seizures			Neurological disorder		
Anemia			Fainting			Organ transplant		
Anxiety/nervousness			Fen-Phen use			Pacemaker		
Arthritis			Fibromyalgia			Psychiatric disorder		
Artificial heart valve			Glaucoma			Psychiatric/Psychological care		
Artificial joints			Hay fever			Radiation treatment		
Asthma			Head/neck injury			Rheumatic fever		
Autoimmune disease			Chroni headaches			Scarlet fever		
Blood transfusion			Heart attack			Shortness of breath		
Cancer			Heart disease			Sickle cell disease		
Cerebral palsy			Heart murmur			Sinus trouble		
Chemotherapy			Heart surgery			Sjonren’s disease		
Chest pain			Hemophilia			Skin rash		
Chronic cough			Hepatitis A			Sleep apnea		
Cold sores			Hepatitis B			Stroke		
Congenital heart disease			Hepatitis C			Swollen ankles		
Contact lenses			Herpes			Thyroid disease		
Convulsions			High blood pressure			Tuberculosis		
Cortison medicine			HIV positive			Tumors		
Chroni diarrhea			Indwelling defibrillator			Ulcers		
Depression			Jaundice			Venereal disease		
Diabetes			Kidney disease					
Dialysis			Latex sensitivity					

16. Do you have any other diseases or illness not covered on the previous page?    Yes    No  
 If yes, please list:

17. Have you had replacement surgery?    Yes    No  
 If yes, please list:

18. Do you have surgical implants?      Yes      No			
If yes, please list:			
19. Do you currently use recreational drugs?      Yes      No			
If yes, please list:			
20. Do you use more than two pillows to sleep?      Yes      No			
21. Have you gained or lost more than 10 pounds in the past year?      Yes      No			
22. Are you allergic to any of the following medication? (check all that apply)			
Aspirin	Codeine	Dental anesthetics	Erythromycin
			Latex
			Penicillin
			Tetracycline
Other, please list:			
<b>23. Women Only</b>			
Are you pregnant?	Yes	No	Don't know
Are you nursing?	Yes	No	
Do you have breast implants?	Yes	No	
Are you taking birth control pills?	Yes	No	
Are you taking hormone replacement therapy?	Yes	No	
<p>I have reviewed the information on this form and it is accurate to the best of my knowledge.</p> <p>I understand that this information will be used by Dr. Peter Amundson and his staff to help determine appropriate and healthful dental treatment. If there is any changes in my medical status, I will inform Dr. Amundson. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun I give Dr. Amundson my consent to perform any needed dental treatment.</p> <p>I authorize my insurance company to pay Dr. Amundson all insurance benefits otherwise payable to me for services rendered</p> <p>I authorize the use of this signature on all insurance submissions.</p> <p>I authorize Dr. Amundson to release all information necessary to secure the payment of benefits.</p> <p><b>I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.</b></p> <p>When you arrive for your appointment we will have you sign and date your Medical and Dental History as required by law.</p>			
<b>Name:</b>			
<b>Signature:</b>		<b>Date:</b>	
Payment is due in full at time of treatment unless prior arrangements have been made.			
I also agree to give consent to the use of photographs for patient education, my full name will not be included:			
<b>Name:</b>			
<b>Signature:</b>		<b>Date:</b>	
This information in NOT shared with anyone outside this office. This material is strictly confidential and collected solely for the use of this office to process for your medical/dental records chart. This data will be stored in you dental record. This information will not be shared with anyone without written consent that is signed and dated <i>only by you</i> .			
<b>Name:</b>			
<b>Signature:</b>		<b>Date:</b>	

Submit