IMPLANTS PRO CENTER©

ROBOT-ASSISTED SURGERY WITH A HUMAN TOUCH

## Medical Record

First Name: _____ Last Name: _____ Date: ___/___/___

Do you have a personal physician? Yes / No Physician's Name: _____ Physician's Ph #: _____ Date of Last Visit: ___/___/___

Traveled outside the U.S. in the last 6 months? Yes / No Please specify where: _____ For how long? _____

Anything you would like to discuss with the doctor in private? Yes / No

## Dental History

Why have you come to the dentist today? _____

If you are a new patient, when did you see a dentist last time? _____ Why? _____

| | |
|---|---|
| Your current dental health is: | Good / Fair / Poor |
| Have you ever taken Phen – Phen / Redux & Pondimin? | Yes / No |
| Have you ever taken Bisphosphonates? | Yes / No |
| Do you require antibiotics before dental treatment? | Yes / No |
| Are your teeth sensitive to heat, cold, currently in pain? | Yes / No |
| Have you ever had gum treatment or bleeding gums? | Yes / No |
| Have you ever had a problem w/ any previous dental work? | Yes / No |
| Have you ever experienced pain/discomfort in your jaw joint-TMJ? | Yes / No |
| Do you like your smile? | Yes / No |
| Do you like the shade of your teeth? | Yes / No |
| Would you like your teeth to be whitened? | Yes / No |

## Allergens

☐ No known allergens ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Local Anesthetics ☐ Penicillin ☐ Sedatives ☐ Sulfa Drugs

☐ Antibiotics ☐ Barbiturates ☐ Erythromycin ☐ Latex ☐ Metals ☐ Plastic ☐ Sleeping Pills ☐ Tetracycline

## Current Medications

| Medicine | Dosage / Frequency | Reasons |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Patient Signature:** _____ **Date:** ___/___/___

450 Sutter St, Rm 1905
San Francisco, CA 94108

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info@implantsprocenter.com

415.391.7751
415.391.7357

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## Medical History

| Medical Condition | Never | Current | Past | Date / Note | Medical Condition | Never | Current | Past | Date / Note |
|---|---|---|---|---|---|---|---|---|---|
| Acid Reflux | | | | | Hospitalized | | | | |
| Anemia | | | | | Hypertension | | | | |
| Atherosclerosis | | | | | Hypoglycemia | | | | |
| Arthritis | | | | | Immune System Disorder | | | | |
| Asthma | | | | | Insomnia | | | | |
| Autoimmune Disorder | | | | | Ischemic Heart Disease (reduced blood supply) | | | | |
| Bleeding Easily | | | | | Kidney Problems | | | | |
| Blood Pressure - High | | | | | Liver Disease | | | | |
| Blood Pressure - Low | | | | | Meniere's Disease | | | | |
| Bruising Easily | | | | | Metal Rods, Pins Or Implants | | | | |
| Cancer | | | | | Mitral Valve Prolapse | | | | |
| Chemotherapy | | | | | Mood Disorder | | | | |
| Chronic Fatigue | | | | | Multiple Sclerosis | | | | |
| Chronic Pain | | | | | Muscular Dystrophy | | | | |
| COPD | | | | | Nasal Allergies | | | | |
| Coronary Heart Disease | | | | | Neuralgia | | | | |
| Current Pregnancy | | | | | Osteoarthritis | | | | |
| Depression | | | | | Osteoporosis | | | | |
| Diabetes | | | | | Parkinson's Disease | | | | |
| Difficulty Sleeping | | | | | Prior Orthodontic Treatment | | | | |
| Dizziness | | | | | Psychiatric Problems | | | | |
| Emphysema | | | | | Radiation Treatment | | | | |
| Epilepsy | | | | | Rheumatic Fever | | | | |
| Excessive Daytime Sleepiness | | | | | Rheumatoid Arthritis | | | | |
| Fibromyalgia | | | | | Shingles | | | | |
| Frequent Headaches | | | | | Sickle Cell Disease/Traits | | | | |
| Glaucoma | | | | | Sinus Problems | | | | |
| Gout | | | | | Sleep Apnea | | | | |
| Heart Attack | | | | | Stroke | | | | |
| Heart Murmur | | | | | Tendency For Ear Infections | | | | |
| Heart Pacemaker | | | | | Thyroid Disorder | | | | |
| Heart Valve Replacement | | | | | Tuberculosis | | | | |
| Hemophilia | | | | | Tumors | | | | |
| Hepatitis | | | | | Ulcers | | | | |
| Herpes / Fever Blisters | | | | | Urinary Disorders | | | | |

Other (Please Specify): _____

**Patient Signature:** _____ **Date:** ___/___/___

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## Confidential Medical History

| Medical Condition | Never | Current | Past | Date / Note |
|---|---|---|---|---|
| Recreational Drugs | | | | |
| HIV / AIDS | | | | |

| Medical Condition | Never | Current | Past | Date / Note |
|---|---|---|---|---|
| Other (Please Specify): | | | | |
| Other (Please Specify): | | | | |

## Surgical Operations

☐ Appendectomy ☐ Ear ☐ Heart ☐ Lung ☐ Thyroid ☐ Uvulectomy ☐ Other: _____

☐ Back ☐ Gallbladder ☐ Hernia Repair ☐ Nasal ☐ Tonsillectomy ☐ Periodontal ☐ Other: _____

## Family History

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Diabetes ☐ Stroke ☐ Obesity ☐ Father Snores ☐ Father Has Sleep Apnea

☐ Heart Disease ☐ High Blood Pressure ☐ Sleep Disorder ☐ Thyroid Disorder ☐ Mother Snores ☐ Mother Has Sleep Apnea

## Social History

Patient's Occupation: _____ Employer: _____

**Tobacco Use:** **Cigarettes:** ☐ *Never Smoked* ☐ *Current Smoker* ☐ *# Of Packs Per Day* ☐ *# Of Years* ☐ *Quit* *When?* _____

**Other tobacco:** ☐ *Pipe* ☐ *Cigar* ☐ *Snuff* ☐ *Chew*

**Alcohol Use:** Do you drink alcohol? *Yes / No* *If yes, # of drinks per week:* ☐

**Caffeine Intake:** ☐ *None* ☐ *Coffee* ☐ *Tea* ☐ *Soda* *# Cups Per Day* ☐

**Additional:** ☐ *Regular exercise*

## Declaration

*Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required, including a full report of examination findings, diagnosis, and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges, whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.*
*I certify that the medical history information is complete and accurate.*
*I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.*

**Patient Signature:** _____ **Date:** ___/___/___

**Doctor Signature:** _____ **Date:** ___/___/___

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