

# Premier Dental Designs

*Exceptional Smiles Through Exceptional Dentistry*

Guest Name \_\_\_\_\_

1. *List all medications you are currently taking and their purpose:*

2. *Are you allergic or had an adverse reaction to any medication or substance? If so please list:*

3. *Do you have or have you had: ( Please circle all that apply to you)*

Heart Problems

Chest Pain

Heart Murmur

High Blood Pressure

Mitral Valve Prolapse

Artificial Heart Valve

Neurological Disorders

Rheumatic Fever

Stroke

Artificial Joints

Kidney Trouble

Diabetes

Thyroid Problems

Tuberculosis

Asthma

Latex Sensitivity

Allergies/ Hives

Heart Pacemaker

Radiation Therapy

Chemotherapy

Tumors

Hepatitis A, B, or C

AIDS

HIV (+)

Blood Transfusion

Hemophilia

Liver Disease

Sinus Trouble

Epilepsy/ Seizures

Fainting/ Dizziness

Nervousness

Psychiatric/

Psychological Care

Any other Condition(s) not listed: \_\_\_\_\_

Women: Are you:

Pregnant

Nursing

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.*

Guest or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_