JAMES D. LUND DDS

MEDICAL/DENTAL HEALTH INFORMATION

Patient Name_____ Date_____

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No If yes, please list name of medication and reason.

_____

_____

DENTAL HISTORY

Please mark appropriate box if you have had any of the following:

	YES	NO		YES	NO		YES	NO
Bad breath	☐	☐	Grinding teeth	☐	☐	Periodontal treatment	☐	☐
Bleeding gums	☐	☐	Gums swollen/tender	☐	☐	Sensitivity to cold	☐	☐
Blisters on lips/mouth	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to hot	☐	☐
Burning sensation on tongue	☐	☐	Lip/cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Chew on one side of mouth	☐	☐	Loose teeth	☐	☐	Sensitivity when biting	☐	☐
Clicking/popping jaw	☐	☐	Mouth breathing	☐	☐	Sore/growths in mouth	☐	☐
Dry mouth	☐	☐	Orthodontic treatment	☐	☐	Use of tobacco	☐	☐
Fingernail biting	☐	☐	Pain around ear	☐	☐	How often do you brush_____		
						How often do you floss_____		

MEDICAL HISTORY

Please mark appropriate box if you have had any of the following:

	YES	NO		YES	NO		YES	NO
Aids/HIV	☐	☐	Epilepsy	☐	☐	Radiation Treatment	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Respiratory Disease	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic Fever	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Scarlet Fever	☐	☐
Artificial Joints	☐	☐	Heart Murmur/pre-med?	☐	☐	Shortness of Breath	☐	☐
Asthma	☐	☐	Heart Problems/pre-med?	☐	☐	Sinus Trouble	☐	☐
Back problems	☐	☐	Hepatitis Type_____	☐	☐	Skin Rash	☐	☐
Bleeding, abnormal	☐	☐	Herpes	☐	☐	Special Diet	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Cancer _____	☐	☐	Jaundice	☐	☐	Swollen feet/ankles	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Swollen Neck Glands	☐	☐
Chemotherapy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems	☐	☐
Circulatory Problems	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Congenital Heart Lesions	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Cortisone Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Tumor/growth_____	☐	☐
Cough, persistent or bloody	☐	☐	Nervous Problems	☐	☐	Ulcer	☐	☐
Diabetes_____	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐
Emphysema	☐	☐	Psychiatric Care	☐	☐	Weight Loss, unplanned	☐	☐

ALLERGIES

☐ Aspirin ☐ Barbiturates(sleeping pills) ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other_____ ☐ None

***** PLEASE CONTINUE TO REVERSE SIDE OF THIS FORM *****

CONTINUED FROM REVERSE SIDE:

Patient Name_____
Reason for today's visit_____
Date of last dental visit_____ Date of last dental x-rays_____
Are you under the care of a physician? □ Yes □ No If yes, please explain:_____
Name of Physician_____ Phone Number_____
Do you require pre-medication for a medical condition? □ Yes □ No If Yes, with:_____
Have you ever taken any drugs related to fen-phen?" (Ionimin, Adipex, Fastin, Pondimin, & Redux) □ Yes □ No
Have you ever taken any bisphosphonate drugs? (Fosamax, Actonel, Boniva, or others) □ Yes □ No
Women: Taking birth control pills? □ Yes □ No Are you pregnant? □ Yes □ No If yes, due date:_____

CONSENT TO PROCEED

- I certify these answers are accurate and correct to my knowledge. Since the change of medical conditions/medications can affect dental treatment, I understand the importance of and agree to notify Dr. James D. Lund and/or any associate(s)/employee of any changes at any subsequent reservation/appointment.
- I authorize James D. Lund, D.D.S. and/or such associate(s) or assistant(s), as he/she may designate, to perform necessary procedures to maintain my dental health or the dental health of any minor or other individual(s) I am responsible for. These procedures include, but are not limited to, arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.
- I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include but are not limited to: bruising, hematoma, cardiac stimulation, temporary or permanent numbness and muscle soreness. I understand that on rare occasion(s) needles break and surgical retrieval may be required.
- I understand that as part of dental treatment, including preventive procedures such as hygiene cleanings and basic dentistry including restorations of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek(s) or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.
- I understand that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.
- I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child(ren). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

_____	_____	_____
Patient Name/Legal Guardian (Print)	Signature of Patient/Legal Guardian	Date
_____	_____	_____
Witness Name (Please print)	Signature of Witness by Office Personnel	Date

UPDATES – To be completed at later dates

Have there been any changes in your health since your last dental visit? If yes, please explain.

CHANGE/NEW MEDICATIONS (or N/A)	**Patient/Legal Guardian Signature**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____