Crofts Family Dental
128 S Adams Jerome ID, 83338 (208) 324-3596

Patient Medical History:

Are you under medical treatment now?

Yes or No

Are you taking any medications? If yes, specify or present list of medications.

Yes or No

Have you ever taken Fen-Phen/Redux?

Yes or No

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphosphates?

Yes or No

Are you on blood thinners?

Yes or No

Do you use tobacco?

Yes or No

Do you use controlled substances?

Yes or No

Are you allergic to (circle if yes):

Local Anesthetics

Penicillin or any other antibiotics

Sulfa drugs

Barbiturates

Sedatives

Iodine

Aspirin

Any metals

Latex

Other, please list:

Women Only:

Are you pregnant or think you may be?

Yes ☐ No ☐

Are you nursing?

Yes ☐ No ☐

Are you taking oral contraceptives?

Yes ☐ No ☐

Dental History:

Do you:

Feel any pain in your teeth?

Yes ☐ No ☐

Have sores or lumps in or near your mouth

Yes ☐ No ☐

Have joint pain in your jaw?

Yes ☐ No ☐

Have frequent headaches?

Yes ☐ No ☐

Have difficulty opening or closing?

Yes ☐ No ☐

Like your smile?

Yes ☐ No ☐

	Yes	No
Angina		
Asthma		
Cancer		
Cardiac Pacemaker		
Chest Pains		
Diabetes		
Easily Winded		
Empysema/COPD		
Heart Attack		
Heart Disease		
Heart Murmur		
Hepatitis		
High Blood Pressure		

	Yes	No
Low Blood Pressure		
HIV/AIDS		
Joint Replacement/Implant		
Kidney Disease		
Leukemia		
Liver disease		
Mitral Valve Prolepses		
Radiation Therapy		
Rheumatic Fever		
Seizers/Epilepsy		
STD's		
Stomach problems/Ulcers		
Stroke		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examinations 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 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 of service. I agree to be responsible for payment of all services rendered on behalf of my dependents.

X _____ Date: _____