Andrew D. Gruver D.D.S. & Associates, P.A.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US PROVIDE THE BEST DENTAL CARE POSSIBLE FOR YOU.

Last Name _____ First Name _____ Middle Initial _____ (Nickname) _____

Residence Address _____ _____
Street City State Zip code Home Phone

Date of Birth _____ Referred by _____ If under 18, Name of parent or guardian _____

Marital status, Single _____ Married _____ Divorced _____ Spouse's name _____ Spouse's date of birth _____

Employer's name _____

Business address _____ _____
Street City State Zip code Business Phone

Dental insurance carrier _____ Policy number _____

When was your last complete physical examination by your personal physician? Month _____ Year _____

Have you ever been hospitalized? Yes ___ No ___ For what reason and date? _____

Are you taking any Medications now? Yes ___ No ___ Please List Medication and what it is treating _____

_____

Physician's name and address _____ Phone number _____

Person to contact in case of an emergency _____ Phone number _____

Have you ever had or do have any of the following?

	Yes/No		Yes/No		Yes/No
Heart condition or problems		Asthma		Osteoporosis or Osteopenia	
Cardiac pacemaker		Lung or breathing problems		Radiation therapy	
Cardiac bypass surgery		Emphysema		Chemotherapy or bone marrow transplant	
Cardiac catheterization or stent		Tuberculosis		AIDS or HIV positive	
Heart valve replacement surgery		Sinus problems, symptoms or surgery		Herpes or fever blisters	
Rheumatic fever		Arthritis		Sjogren's syndrome	
Angina		Difficulty in wound healing or unhealed sores		Dry Mouth (xerostomia)	
Heart Attack		Kidney disease or problems		Drug Abuse	
Heart Murmur		Kidney Dialysis		Alcoholism	
Mitral valve prolapse		Diabetes		Other infectious diseases	
Defective heart valves or heart chambers		Stomach problems			
Congestive heart failure		Colitis or Crohn's Disease		Allergic reactions to any of the following:	
Stroke		Thyroid Problems			
Hypertension- High blood pressure		Hepatitis, yellow jaundice or other liver problems		Local anesthetics/ Novocaine	
Hypotension- Low blood pressure		Psychiatric (mental) problems or disorders		Penicillin or other antibiotics	
Anemia		Nervous conditions or disorders		Codeine or other narcotics	
Hemophilia or bleeding disorders		Fainting or dizzy spells		Aspirin or Ibuprofens	
Excessive Bleeding following surgery		Seizures or epilepsy		Latex	
Blood transfusions		Venereal (sexually transmitted) diseases		Other:	
Prosthetic joint replacement		Cancer		_____	
(Artificial replacement of knee, or hip		Any organ donations or transplants		_____	
and/or placement of pins or screws)		Do you use any tobacco products?		_____	

Women: Are you pregnant or do you think you are pregnant? Yes _____ No _____ If Pregnant, how many months? _____

Do you take birth control pills? Yes _____ No _____

Are you aware of the adverse interaction between antibiotics and the pill? Yes _____ No _____

Do you need to take antibiotic premedication before dental appointment? Yes _____ No _____

If so, Name of antibiotic _____

Do you have any medical or dental condition or problems that you have not mentioned above? Yes _____ No _____

List: _____

I certify to the best of my knowledge that this information is accurate and complete. I will inform Dr. Gruver & Dr. Okamoto and/or his staff members of any health changes or changes in the medication I take.

Signature _____ Date _____
Patient, Parent or guardian

PLEASE DO NOT WRITE BELOW THIS LINE

CURRENT MEDICATIONS AND/OR SIGNIFICANT MEDICAL HISTORY

REVIEWED WITH PATIENT _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Date Initials Date Initials Date Initials Date Initials Date Initial

Date	Medical Update	Dr.	Pt.