Garden Spot Dental Care, PC

101 West Main Street • New Holland, PA 17557 (717)354-3200

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Medical Alerts
- ☐ Allergy - Aspirin
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Artificial Valve
- ☐ Bleeding Disorder
- ☐ Diabetes Type I/II
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Tobacco Use
- ☐ Viagra/Cialis
- ☐ *Pre-Med - Amox
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Anxiety/Depression
- ☐ Asthma/COPD
- ☐ Blood Disease
- ☐ Dizziness/Fainting
- ☐ Head/Neck Injuries
- ☐ Hepatitis A_B_C
- ☐ Kidney Disease
- ☐ Other
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ *Pre-Med - Clind
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Blood Thinners
- ☐ Epilepsy/Seizures
- ☐ Heart Attack/Stroke
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker/Stents
- ☐ STD/HPV
- ☐ Tumors/Growths
- ☐ *Pre-Med - Other
- ☐ Allergy - Latex
- ☐ Alzheimer's/Dementia
- ☐ Artificial Joints
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ GI/Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Mental Illness
- ☐ Radiation/Chemo
- ☐ Thryoid Disorder
- ☐ Ulcers

- ☐ Recent hospitalization (illness or injury)
- ☐ Pregnant/Planning Pregnancy/Nursing
- ☐ Frequent headaches or migraines
- ☐ No Medical Condition
- ☐ Presently being treated for any other illness
- ☐ No Medications

If any conditions or alerts selected needs further clarification, please describe below

_____

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

Describe any current medical treatment, recent or impending surgery, hospitalizations or other treatment.

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list any allergies and/or allergies to medications.

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.**

Name of Patient/Parent or Guardian completing this form *

Response Date: ____/____/_____