J. Flint Tomlinson, DMD

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Medical History

Patient Name: _____ _____ ____ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergy
- ☐ Allergy Anesthetics
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - Lortab
- ☐ Allergy - Metals
- ☐ Allergy - Oxycodone
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy -Amoxicillian
- ☐ Allergy -Aspirin
- ☐ Allergy -Clindamycin
- ☐ Allergy -Erythromycin
- ☐ Allergy -Invans
- ☐ Allergy -Keflex
- ☐ Allergy -Morphine
- ☐ Allergy -Tetracycline
- ☐ Allergy -Zithromax
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cephalexin
- ☐ Codeine
- ☐ Dementia
- ☐ Demoral
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ HIV
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loratab
- ☐ Lupis
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Penicillin
- ☐ Percocet
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Tylenol 3
- ☐ Ulcers
- ☐ Venereal Disease

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

_____

_____

Name of your Physician and Phone Number:

_____

_____

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ * **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. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)

Name of Insured: _____ * (Last) _____ * (First) ____ (MI)

Patient's relationship to insured: * ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: * _____

Response Date: _____