Alternative Dental Care

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Registered Dental Hygienist in Alternative Practice
www.alternativedental.com

Patient Information

Please Print: Dr. ☐ Mr. ☐ Mrs. ☐ Ms.☐
Patient Name: _____Date of Birth_____
Home Address: _____Home Phone_____
City, State, Zip:-_____SS# (if Delta Ins. Only)_____
Name of Special Care Facility:_____
Facility Address:_____
City, State, Zip: _____Facility Phone:_____
Facility Contact Name:_____Title:_____
Name of Physician:_____Phone:_____
Physician Address: _____City, State, Zip:_____
Name of Last Dentist:_____Phone:_____
Dentist Address: _____City, State, Zip:_____
Last Dental Visit: _____Last Dental Cleaning:_____
To whom can I thank for referring you?: _____

Medical History

Some illnesses and drugs may make an alteration to patient treatment. In order to provide the best possible care, please complete this area by checking any box that applies or filling in specific lines:

Antibiotics ☐ Insulin ☐ Hormones ☐ tranquilizers/antidepressants☐ Steroids ☐ Diet Supplements ☐
Blood Thinner/anticoagulants ☐ Blood Pressure Medication ☐ Any Heart Medication ☐

Are there any known allergies? If so List:_____

Check any conditions that apply:
History of rheumatic fever ☐ high blood pressure ☐ heart attack ☐ stroke ☐ pacemaker ☐ diabetes ☐
hip, knee or any joint replacement? ☐ if so, have antibiotics every been required for dental care? ☐
Please list name of antibiotics prescribed for dental care, and the doctor that prescribed:

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hearing impaired?☐ hepatitis/jaundice/liver disorder ☐ recent blood transfusion ☐ kidney disorder ☐
persistent/chronic cough ☐ tuberculosis ☐ lung disorder ☐ cancer history ☐ radiation/chemo history ☐
ulcer ☐ GERD/reflux ☐ osteoporosis ☐ arthritis ☐ epilepsy/convulsions ☐ impaired vision ☐
psychiatric treatment ☐ Alzheimer's disease/dementia ☐ cerebral palsy ☐ multiple sclerosis ☐
Parkinson's disease ☐
Do you have any disease, condition, or problem not listed? _____
_____

List all medications prescribed: _____
_____