Alexis A. Atchinson, DDS, PC

"Creating Healthy Smiles"

Name: _____ Date of Birth: _____

Medical Doctor: _____ Clinic Name: _____
Medical Specialist (If any): _____

Have you been hospitalized during the past Year? No_____ Yes_____
Have you been treated by a physician during the past year? No_____ Yes_____
Have you had, or do you have a family history of, reaction to local anesthetic? No____ Yes_____
Have you ever had a problem with prolonged bleeding? No_____ Yes_____
Have you ever used blood thinning drugs? No_____ Yes _____
If female, are you pregnant or possibly pregnant? No _____ Yes _____ (# weeks? ___)
Are you current on Immunizations? No _____ Yes _____

List all medications you are taking & state why:

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List all medications you are taking & state why:

1._____
2._____
3._____
4._____
5._____
6._____
7._____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE NOW:

__AIDS/HIV
__Arthritis
__Artificial Joint
__Asthma
__Sinus/Allergy trouble
__Emphysema
__Cough- Persistent of Bloody
__CPAP-Sleep Apnea, Snoring
__Tuberculosis (TB)
__Cancer Type? _____
__Chemotherapy / Radiation Treatments
__Are you currently being treated?
__ Endocrine Problems
__Epilepsy
__ Thyroid
Hypo ___ Hyper___
__ Back/Spine issues

__Heart Problems- Type: _____
__Heart Surgery –Type: _____
__Heart Valve Problems
__Pacemaker (when was it placed?)_____
__Stroke- Any residual complications:
__High Blood Pressure
Is it being treated? ____
__Diabetes Type1___ Type2____
__Kidney/Liver Disease
__Glaucoma
__Latex Allergy
__Osteoporosis
__History of Bisphosphonates
__ MRSA/Staph problems
__Dry Mouth
__Psychiatric Treatment

__Tobacco Use:
Chew __ Smoke __
Current__ Past __
__ Recreational drugs Type:_____
__ OMMP
__Chemical Dependency(Drug/Alcohol)
__Tumor growth of the head or neck
__Hepatitis- type: _____
__Herpes lesions (cold Sores fever blisters)
__Gastric problems Type_____
__GERD
__Ulcers
__Unintentional Weight Loss
Any other disease, conditions, or surgery not listed:
_____
_____
_____

*****Certain health conditions also affect your oral health and /or ability to safely perform dental treatment. Some conditions require pre-medication with an antibiotic prior to dental work and some require that we consult with your physician.

To the best of my knowledge the preceding answers are true and correct. If I ever a change in my health or if the medicines I take change, I will inform Dr. Atchinson at my next appointment.

Patient's Signature_____ **Today's Date**_____

ASA# ____ / ____ / ____ .