Peter W. Piche D.D.S.
Spencer W. Olson, D.D.S.

Name: _____ Birth date: _____ Date: _____
Address: _____ Phone: _____
Email: _____ Cell Phone: _____

Appointment Reminder Preference

Text: ____ Cell Carrier: _____ or Call: _____Home or Cell (Circle One) Email: ___

Health History

Have you ever had any complications following dental treatment? _____
If yes, please explain: _____
Have you ever had any reactions to medications or anesthetics? _____Please explain: _____
Has your physician or dentist recommended taking antibiotics before dental treatment? _____
Do you use tobacco of any type?_____ How much/often? _____
Are you presently taking any medications? _____Please list or attach list and dosage:_____
_____
Are you presently taking any herbal supplements or OTC medicine? Please list: _____
Any allergies to: Penicillin____Codeine____Sulfa____ Other medications: _____
Allergies to food: ____ If yes, please list: _____
Have you ever taken biphosphonate drugs? (ex. Fosomax, Boniva)_____For how long?_____
Recent surgeries or hospital stays? _____

Have you ever had any of the following? Please check the box to the left of your selection:

	Artificial joints		Stent(s) Date:		Chemo/Radiation		Immuno-compromised
	What joint:		High/Low BP		Tumors		Pregnant Due date:
	Surgery date:		Endocarditis		Surgery Date:		Rheumatic/Scarlet
	Osteoporosis/penia		Stroke		Crohn's Disease		Sinus problems
	Degenerative disks		Anemia		Digestive problems		TMJ
	Head/Neck/Back		Hepatitis Type:		Eating disorder		Vitamin deficiencies
	Arthritis		High Cholesterol		GERD		AIDS/HIV
	Heart murmur		Asthma		IBS		Cold/Canker sores
	Mitral valve prolapse		Kidney Disease		Ulcers		ADD/ADHD
	Heart Surgery		Liver Disease		Diabetes Type:		Alzheimer's/Dementia
	Surgery date:		Lung Disease/COPD		Menopause/HRT		Epilepsy
	Heart attack		Tuberculosis		Thyroid		Fainting
	Date:		Hearing/Visual impaired		Glaucoma		Mental Disorders
	Pacemaker		Cancer		Handicaps/Disabilities		Multiple Sclerosis
	Date placed:		Type: Date:		Hay Fever		Nervous Disorders

Clinician notes:

_____
_____
_____

Please list your current Physician and/or Specialist Information

Name of family physician: _____ Phone: _____
Please list any other physician/specialist:_____

Patient's signature:_____Date: _____Reviewed by:_____
As parent/guardian I have completed this form to the best of my knowledge.Signature of parent/guardian:_____Date: _____