Pearl Dental Center
laboratory & clinics

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Medical Status Form

Name: ……..

Address: ……

Birth date:…….

Gender:……..

Phones: Home:……..... Work:…….

Mobile:…….....… Fax:……

Email:…….

The dentistry you receive has an important interrelationship with the health problems that you may have, or medications you are taking. It is imperative that you provide the following information to help us treat you as effectively and safely as possible.
Please initial that you read this paragraph:……..

1- Are you under a physician's care now? ( ) yes ( ) no If yes, please explain:
Dr. Name:
Address:
Telephone Number:
Date of last physical exam

2- Have you ever been hospitalized or had a major operation in the past five years?
( ) yes ( ) no If yes, please explain:

_____

3- Have you ever had a serious head or neck injury?
( ) yes ( ) no If yes, please explain:

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4- Are you taking **any** prescription or nonprescription medications, pills, herbal supplements, aspirin, ibuprophen, vitamin (E) or drugs?
( ) yes ( ) no If yes, please list and explain:

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