solstice DENTISTRY

Ben Belfiglio, DDS Debbie Wrigley, DDS

MEDICAL HISTORY

Patient Name (Legal as on Insurance): _____

Have you ever had an unfavorable reaction to dental work? _____

Name of Family doctor or Specialists (Cardiologists, etc.)? _____

Are you ALLERGIC or had an unfavorable reaction to the following:

❑ Penicillin ❑ Clindamycin ❑ Novocaine or other local anesthetics: _____

❑ Latex ❑ Metal _____ ❑ Other drugs:_____

Do you or have you had any of the following: (Please describe Yes responses in Comments Below)

❑ Anemia	❑ Any Surgeries	❑ Arthritis	❑ Artificial Joints
❑ Asthma	❑ Autoimmune	❑ Blood Disease	❑ Cancer – List Type
❑ Chemical Dependency	❑ Diabetes	❑ Dizzy/Fainting	❑ Dry Mouth
❑ Epilepsy	❑ Excessive Bleeding	❑ Gastric Reflux	❑ Glaucoma
❑ Hay Fever/Allergies	❑ Head Injuries	❑ Heart Attack	❑ Heart Disease/Defects
❑ Heart Murmur	❑ Heart Surgery/Valves	❑ Hepatitis/Jaundice	❑ High Blood Pressure
❑ Kidney Disease	❑ Liver Disease	❑ Mental Disorders	❑ Nervous Disorders
❑ Pacemaker	❑ Radiation/ Chemo	❑ Need Wheelchair	❑ Respiratory Problems
❑ Rheumatic Fever	❑ Rheumatoid Arthritis	❑ Sinus Problems	❑ Stomach Problems
❑ Stroke	❑ Tuberculosis	❑ Tumors	❑ Ulcers

Have you ever taken drugs for bone strength or osteoporosis (Boniva, IV, etc.)? _____

Comments or anything else we should be aware of: _____

_____

Are you pregnant? If yes, when are you due? _____

Please list any medications you are currently taking (or provide a list we can copy):

_____

_____

Signature: _____ Date: _____