

IMPLANTS • INVISALIGN • COSMETIC DENTISTRY • CEREC/3D

WELCOME TO DR. FRONING'S OFFICE. WE SINCERELY APPRECIATE YOU CHOOSING OUR OFFICE FOR YOUR DENTAL AND ORAL HEALTH CARE NEEDS. PLEASE BE ASSURED THAT WE WILL WORK HARD TO CONTINUALLY EARN THE TRUST THAT YOU HAVE PLACED IN US. IN ORDER FOR US TO SERVE YOU BETTER, PLEASE TAKE SOME TIME TO COMPLETE THIS INFORMATION FORM AS THOROUGHLY AS POSSIBLE.

MEDICAL HISTORY UPDATE

Your Name _____ Today's Date _____

Physician's Name _____ Phone # _____

When was your last visit to your physician? _____

When was your last complete physical? _____

Please tell us if you have had any of the following by checking the appropriate box

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Bacterial Endocarditis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Any Artificial Replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Disease | Artificial Knee, Hip, Joint, | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Sickle Cell Anemia | Pins, Plate ____ year | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia/Blood Problems | <input type="checkbox"/> Rheumatism/Arthritis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Heart Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Attack ____ year | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Eye Disorders/Glaucoma | <input type="checkbox"/> Tobacco Dependency | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Pregnant ____ months |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Immunosuppressive | <input type="checkbox"/> Cancers, Tumors, Growths | <input type="checkbox"/> Planning to be pregnant soon |
| <input type="checkbox"/> Stomach Problems/Reflux | Disorders/ARC | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Oral Contraceptives |

Please list any ALLERGIES to Drugs, Medications or Anesthetics _____

Please list any other MEDICAL CONDITIONS not mentioned above _____

Please list all DRUGS/MEDICATIONS that you currently take _____

 Patient's (Guardian's) Signature

 Date

 Dentist's Signature

 Date

