Weldon General and Cosmetic Dentistry

Daniel A. Weldon, DMD, PLLC
812 NE 25th Ave., Suite B
Ocala, FL 34470
(352)622-3236

General Information:

Patient Name: _____ **Birthdate:** _____/_____/_____

Address: _____ **Male** ____ **Female** ____

City, State, Zip: _____ **Marital Status:** S M D W

Home # (____) _____ **Cell #** (____) _____

Work# (____) _____ **Email:** _____

Social Security #: _____/_____/_____ **Driver's License:** _____

Employer: _____ **Referred By:** _____

Spouse or Parent's Name: _____

Responsible Party Information:

Responsible Party: _____ **Phone #** (____) _____

Address (If different from above): _____

Insurance Information:

Policy Holder Name: _____ **Employer:** _____

Policy Holder SSN: _____/_____/_____ **AND** **Member ID #:** _____

****If we have trouble verifying your policy with ID number insurance company can verify with SSN****

Insurance Company: _____ **Phone #:** (____) _____

Address: _____ **Group #:** _____

_____

I hereby authorize and request dental treatment from Daniel A. Weldon, DMD, PLLC and John F. Berg, DDS, PA., and further authorize the performance and the administration of any anesthetics and analgesics which the above named doctor may deem necessary.

_____ _____

Signature Date

Medical History

Daniel A. Weldon, DMD

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No

If Yes _____

Have you ever been hospitalized or had a major operation? Yes No

If Yes _____

Have you ever had a serious head or neck injury? Yes No

If Yes _____

Are you taking any medications, pills, or drugs? Yes No

Please List _____

_____

_____

Do you take or have you taken Phen-Fen or Redux? Yes No

If Yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

Yes No

If Yes _____

Are you on a special diet? Yes No

Do you use Tobacco? Yes No

Do you use blood thinners (including aspirin)? Yes No

Please List _____

Do you use controlled substances? Yes No

Please List _____

Women: Are you...

Pregnant / trying to get pregnant? Yes No Nursing? Yes No

Taking oral contraceptives? Yes No

Are you allergic to any of the following? (Please Circle)

Aspirin **Penicillin** **Codeine** **Acrylic** **Latex**

Sulfa Drugs **Local Anesthetic** **Metal**

Do you have, or have you had, any of the following? (Please Circle)

AIDS/HIV Positive	Y / N	Cortisone Medicine	Y / N	Hemophilia	Y / N	Radiation Treatment	Y / N
Alzheimer's disease	Y / N	Diabetes	Y / N	Hepatitis A	Y / N	Recent Weight Loss	Y / N
Anaphylaxis	Y / N	Drug Addiction	Y / N	Hepatitis B or C	Y / N	Renal Dialysis	Y / N
Anemia	Y / N	Easily Winded	Y / N	Herpes	Y / N	Rheumatic Fever	Y / N
Angina	Y / N	Emphysema	Y / N	High Blood Pressure	Y / N	Rheumatism	Y / N
Arthritis / Gout	Y / N	Epilepsy or Seizures	Y / N	High Cholesterol	Y / N	Scarlet Fever	Y / N
Artificial Heart Valve	Y / N	Excessive Bleeding	Y / N	Hives or Rash	Y / N	Shingles	Y / N
Artificial Joint	Y / N	Excessive Thirst	Y / N	Hypoglycemia	Y / N	Sickle Cell Disease	Y / N
Asthma	Y / N	Fainting / Dizziness	Y / N	Irregular Heartbeat	Y / N	Sinus Trouble	Y / N
Blood Disease	Y / N	Frequent Cough	Y / N	Kidney Problems	Y / N	Spina Bifida	Y / N
Blood Transfusion	Y / N	Frequent Diarrhea	Y / N	Leukemia	Y / N	Stomach / Intestinal Disease	Y / N
Breathing Problems	Y / N	Frequent Headaches	Y / N	Liver Disease	Y / N	Stroke	Y / N
Bruise Easily	Y / N	Genital Herpes	Y / N	Low Blood Press	Y / N	Swelling of Limbs	Y / N
Cancer	Y / N	Glaucoma	Y / N	Lung Disease	Y / N	Thyroid Disease	Y / N
Chemotherapy	Y / N	Hay Fever	Y / N	Mitral Valve Prolapse	Y / N	Tonsillitis	Y / N
Chest Pains	Y / N	Heart Attack / Failure	Y / N	Osteoporosis	Y / N	Tuberculosis	Y / N
Cold Sores / Fever Blister	Y / N	Heart Murmur	Y / N	Pain in Jaw	Y / N	Tumors or Growths	Y / N
Congenital Heart Disorder	Y / N	Heart Pacemaker	Y / N	Parathyroid	Y / N	Ulcers	Y/ N
Convulsions	Y / N	Heart Trouble / Disease	Y / N	Psychiatric Care	Y / N	Venereal Disease	Y / N
						Yellow Jaundice	Y / N

Have you ever had any serious illness not listed?

If Yes _____

_____

Are you currently, or have you ever been treated for any of the following conditions? Circle Yes or No

Osteoporosis	Yes	No	Multiple Myeloma	Yes	No
Osteoarthritis	Yes	No	Cancer Metastasis to Bone	Yes	No
Osteopenia	Yes	No			

Have you ever taken or been prescribed any of the following medications? If so please indicate dosage and duration.

Reclast Injection	Yes	No	If Yes, list dosage and duration_____
Aredia IV (Pamidronate)	Yes	No	If Yes, list dosage and duration_____
Zometa IV (Zoledronate)	Yes	No	If Yes, list dosage and duration_____
Boniva (Ibandronate)	Yes	No	If Yes, list dosage and duration_____
Fosamax (Alendronate)	Yes	No	If Yes, list dosage and duration_____
Actonol (Risedronate)	Yes	No	If Yes, list dosage and duration_____
Didronel (Etidronate)	Yes	No	If Yes, list dosage and duration_____
Prolia (Denosumab)	Yes	No	If Yes, list dosage and duration_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____