# Scott D. Bunday, DDS

1524 Independence Pkwy., #A-2, Plano, TX 75075

## DENTAL/MEDICAL HISTORY

A complete and accurate health history is essential for proper dental care

**Please fill out both pages and sign the bottom of the second page**

Todayôs Date: _____/_____/_____

Patientôs Name:_____ Male or Female

Patientôs Date of Birth: _____/_____/_____

Physicianôs Name_____

Physicianôs Office Location_____ Phone No.: (_____) _____-_____

Date of last complete physical exam: _____/_____/_____

*Are you currently in good health?.....Yes / No
*Are you currently under medical treatment?....Yes / No
*Are you taking medications regularly?..... Yes / No

**If "yes", please list medications, dosage, and frequency on page (2) of history**

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**Please Check any of the following which you have had or have at present:**.

| | | | |
|---|---|---|---|
| __Congestive Heart Failure | __Anemia | __Thyroid Disease | __Jaundice |
| __Heart Disease or Attack | __Stroke | __Radiation Treatments | __Angina |
| __Kidney Problems or Disease | __Arthritis | __Venereal Disease | __HIV/AIDS |
| __High Blood Pressure | __Ulcers | __Cancer | __Cold Sores |
| __Heart Murmur | __Emphysema | __Rheumatic Fever | __Asthma |
| __Congenital Heart Defect | __Scarlet Fever | __Psychiatric Disorder | __Diabetes |
| __Hepatitis A / B / C | __Artificial Joint | __Heart Surgery | __Tuberculosis |
| __Glaucoma | __Epilepsy/Seizures | | |

Other conditions/diseases not listed:_____

*Have you ever had an allergic reaction to local dental anesthetics or any other drugs used in the dental office?
Yes / No

*Have you had any excessive bleeding requiring special treatment? Yes / No

*Do you Smoke? Yes / No Amount used per day: _____

*Do you use any recreational drugs? Yes / No
Drugs used:_____

**WOMEN ONLY:**

Are you pregnant now? Yes / No Due Date:_____/_____/_____

**DENTAL HISTORY :**

Please check any conditions that you have noticed:

| | | |
|---|---|---|
| __Tenderness | __ Sore Areas in mouth | __Jaw / Ear Pain |
| __Bleeding Gums | __Bad Breath | __Sensitivity to hot / cold / sweets |

Date of Last Dental Exam: _____/_____/_____ Dentist Name/Location: _____

## Check medications that you currently take:

(Please write name of drug, dosage and amount)

__Antibiotics or Sulfa Drugs
__Anticoagulants
__High Blood Pressure Medication
__Steroid Medication
__Antihistamines
__Aspirin
__Insulin / Oral hyperglycemic Medications
__Digoxin or other Heart Regulating Drugs
__Nitroglycerin
__Chemotherapy
__Sleeping Pills
__Psychiatric Drugs
__Birth Control
__Vitamins/Herbal Supplements (List)_____
__Other (List)_____

## Check any allergies that you have:

__Local anesthetic drugs
__Latex
__Penicillin or other antibiotics: _____
__Sulfa Drugs
__Barbiturates, sleeping pills
__Aspirin
__Iodine
__Codeine or other Narcotic medications
__Metals
__Other (List)_____

To the best of my knowledge, all of the preceding questions have been answered to the best of my knowledge and are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Dental Office at the next appointment and realize that I will need to fill out a health history update on a yearly basis.

I understand that if, during the course of my treatment in this office, the Dentist or employee may have an accidental exposure to my blood. A specimen of my blood may be requested and tested for the presence of blood borne diseases. The results of such tests or the exposure will remain confidential and will not become a part of my permanent record.

I will consent to the use of photographs, X-ray films, impressions, and other laboratory tests where they are indicated for the purpose of diagnosing and treatment planning.

I understand that all original dental records, X-ray films, and diagnostic aids are the property of Scott D. Bunday, DDS and cannot be taken, or originals sent from the dental office. Copies will be provided upon written request and sent to another dental facility but will be assessed a fee for X-ray duplicating, copying the chart, and postage which must be paid prior to any chart information being sent.

I understand that if I fail to show for my scheduled dental appointments or fail to give 24 hour cancellation notice that I may be charged a ñMissed Appointmentò Fee and/or not allowed to schedule any further appointments at Scott D. Bunday, DDS.

_____/_____/_____ _____ _____

Date Signature (Patient 18 yrs and older), Parent/Legal Guardian