



Dingus & Rivoli Orthodontics

Are you under a physicians care? For what? _____

Date of last medical visit: _____

Name, address and phone number of your physician? _____

Have you been hospitalized in the last five years? If so, why? _____

Are you currently taking medications (including aspirin)? If so, please list them below:

Medication	Reason	Dosage

Do you have or have you ever had:

- Anemia
- Diabetes
- Epilepsy
- Hepatitis
- HIV
- Cancer

- Rheumatic Fever
- Heart Murmur
- ANY Heart Condition
- High Blood Pressure
- Tested for TB

Allergies:

- Penicillin
- Anesthetics
- Codeine
- Aspirin
- Any Medications

WOMEN: Are you pregnant? Are you using a contraceptive?

Do you have an artificial joint or heart valve implant?

Have you been advised by your MD to premedicate with antibiotics for dental treatment?

Have you been tested for or been told you might have heart disease?

Have you had a radiation treatment for any purpose?

Patient's Signature: _____ Date: _____

Parent's Signature (if Child): _____ Date: _____