BARR DENTAL GROUP
SETTING THE BARR IN DENTISTRY

Barr Dental Group
300 NW 70th Ave #206a,
Plantation, FL 33317
(954) 327-7400

First Name * **Last Name** * **MI**

Although dental personnel primarily treat the area in and around your 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

Have you ever been hospitalized or had a major operation? *

◯ Yes ◯ No

Have you ever had a serious head or neck injury? *

◯ Yes ◯ No

Are you taking any medications, pills, or drugs? *

◯ Yes ◯ No

Have you ever had a serious head or neck injury? *

◯ Yes ◯ No

Are you taking any medications, pills, or drugs? *

◯ Yes ◯ No

Do you take, or have you taken, Phen-Fen or Redux? *

◯ Yes ◯ No

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

◯ Yes ◯ No

Are you on a special diet? *

◯ Yes ◯ No

Do you use tobacco? *

◯ Yes ◯ No

Do you use controlled substances? *

◯ Yes ◯ No

Women: Are you...

- [ ] Pregnant/Trying to get pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics
- [ ] Other

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? *

◯ Yes ◯ No

Comments

Patient, Parent or Guardian

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.

Name *

Sign Form

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.

Relationship to Patient *

Name *

Signature *

Today's Date *