Dental Sedation Medical History

Personal Information

Full Name

Date of Birth

Age

Address

Phone Number

Email

Emergency Contact Name

Emergency Contact Phone

Physician & Insurance

Physician Name

Physician Phone

Insurance Carrier

Medical History

Are you currently under medical care?

- ○ Yes
- ○ No

If yes, please specify:

Have you had any of the following? (Check all that apply)

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease

- [ ] High Blood Pressure
- [ ] Seizures
- [ ] Bleeding Disorder
- [ ] Other

If other, please specify:

Medications & Allergies

List all current medications:

List all allergies (drug/food/etc):

Dental History & Sedation

Have you had sedation or anesthesia before?

- ( ) Yes
- ( ) No

If yes, any complications?

Level of dental anxiety (1 = none, 10 = severe):

For Female Patients

Are you pregnant?

- ( ) Yes
- ( ) No

Are you breastfeeding?

- ( ) Yes
- ( ) No

Additional Information

Other relevant health information: