INNOVATIVE DENTAL DESIGN
BY DR. PAUL BYLIS

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Patient Medical History

Patient's Name____ **DOB**__________________

For Staff use Only
Pre-medication___________________

Medical History:

***Check the conditions that apply to you*:**

☐Anemia/Blood Disease
☐Arthritis
☐Asthma
☐Blood Pressure/High
☐Blood Pressure/Low
☐Cancer_________________
☐Chemotherapy
☐Diabetes I II
☐Epilepsy/Seizures
☐Chemical Dependency
☐Hemophilia/Bleeding Disorder
☐Fainting/Nervous
☐Glaucoma
☐Heart Trouble
☐Pacemaker

☐Hepatitis
☐Liver Disease
☐Herpes Virus/Cold Sores
☐HIV Positive/AIDS
☐**Artificial Joint Replacement** (Pins/Rods)
☐Kidney Disorders
☐Mental Health
☐Migraine Headache
☐**Mitral Valve Prolapse**
☐Neck/Head Pain
☐Phen Fen/Diet Pills
☐Pregnant
☐**Rheumatic Fever**
☐**Heart Murmur**

☐Stroke
☐Thyroid
☐Transplant
☐Tuberculosis
☐Lung Disease
☐TMJ/Clicking Joint
☐Venereal Disease
☐Sinus
☐**Cardiovascular Disease** (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, surgery, stents, shunts, artificial valves)

Yes	No	
☐	☐	Are you taking birth control pills?
☐	☐	Are you taking blood thinners?
☐	☐	Are you nursing?
☐	☐	Do you have persistent cough?
☐	☐	Have you ever had a blood transfusion?

***Are you allergic to*:**
☐Aspirin
☐Codeine
☐Iodine
☐Latex
☐Local Anesthesia
☐Penicillin
☐Sedative/Tranquilizer
☐Sulfa
☐Nickel/Metal
☐Jewelry
☐Other (Specify)
____

Are you being treated by a Physician? ☐Yes ☐No If yes, explain:____
My Primary Medical Physician is____Phone_________________________
Taking Medications: ☐Yes ☐No List all Medications:____

Dental History:

Reason for today's visit: ____ Last Dental Visit ______________________
Are you having pain? ☐Yes ☐No Are your gums bleeding? ☐Yes ☐No Bad Breath? ☐Yes ☐No
Are you happy with the appearance of your teeth? ☐Yes ☐No
If you answered no, what would you like to change?____
Have you ever had an unpleasant dental experience? ☐Yes ☐No Explain:____
In Case of Emergency, Contact:____ Phone__________________________

Authority to Treat

I give Innovative Dental Design by Dr. Paul Bylis the authority to administer dental x-rays, local injections, anesthetics and, if requested, nitrous oxide or a tranquilizer in the subsequent treatment of my case. If I have a medical condition such as a heart murmur that requires premedication, I acknowledge that **it is my responsibility to inform and remind the doctor, assistant or hygienist at the beginning of each visit.**

PLEASE BE AWARE THAT YOU ARE RESPONSIBLE FOR ANY BALANCE THAT IS NOT PAID BY YOUR INSURANCE COMPANY.

The above information is true and complete to the best of my knowledge. I agree to pay my copayment at the time services are rendered. The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______________________________

Patient Signature **Date**