Tsar Dental Excellence
Cosmetic
Restorative
Neuromuscular Dentistry

(561) 833-2364 • Fax (561) 471-1831 • info@TsarDentalExcellence.com • www.TsarDentalExcellence.com
Located in the Amtrust Bank building • 603 Village Boulevard, Suite 304 • West Palm Beach, Florida 33409

MEDICAL HISTORY

First Name:_____Last Name: _____

Your Current Physical Health Is:
Good Fair Poor

Are You Currently Under The Care Of A Physician? YES NO
If So, Please Specify?
_____
_____
_____
_____

Family Physician's Name
_____

Physician's Phone
_____

Are You Taking Any Drugs Or Medications? YES NO

If So, Please List Each One Or attach a list
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

To The Best Of Your Knowledge, Are You Or Have You Ever Been Afflicted With These:

Joint Replacements	YES	NO
Do you or did you ever take actonel, fosamax?	YES	NO
Rheumatic	YES	NO
Epilepsy	YES	NO
High Blood Pressure	YES	NO
Respiratory Disease	YES	NO
Hepatitis	YES	NO
Prolonged bleeding	YES	NO
Healing Complications	YES	NO
Heart Ailments	YES	NO
diabetes	YES	NO

Do You Have Any Known Allergies?
If So, Please List Each One: YES NO
_____
_____

Are You Allergic To Any Medications?
If So, Please List each One: YES NO
_____
_____

Do you need to premedicate with antibiotics for dental procedure? YES NO

For Women:
Are You Taking Birth Control? YES NO
Are You Pregnant? YES NO
Are You Nursing? YES NO

Person to contact in case of an of emergency:_____phone: _____

I consent to whatever dental procedures and anesthetics are necessary for the treatment for the patient listed on this form. I also agree to assume full financial responsibility for all treatment rendered.

Patient Signature (Or Legal Guardian) _____Date _____