Toni Calvo Waldbaum DDS
GENTLE FAMILY DENTISTRY

Toni Calvo Waldbaum, DDS
207 SW 156th Street, Suite 4, Seattle, WA 98166
206.246.1424 | office@tonicalvowaldbaum.com

Patient Information:

Today's Date____________________

Name____ I Prefer to be Called______________

Address____________________________________City___________State________Zip__________

Home Phone_________________ Cell Phone_________________ Work Phone__________________

Birthdate_____________ Age____________ Email____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single

Employed by_______________________________________ Occupation________________________

In Case of Emergency Notify___________________________ Phone Number_____________________

Dental History:

Former Dentist_______________________________ Phone Number___________________________

Date of Last Dental Care_______________________

Are you currently in any Dental Discomfort at this Time? ☐ Yes ☐ No
Do You Require Antibiotics Before Dental Treatment? ☐ Yes ☐ No
Do You Snore? ☐ Yes ☐No
Do You Have Sleep Apnea? ☐Yes ☐ No
Do You Suffer From Dry Mouth? ☐ Yes ☐ No
Do You Experience any "TMJ" Problems? ☐Yes ☐No

Medical History:

Physician__________________________________ Phone Number_____________________________

Date of Last Visit____________________________

Are you currently under your physician's care? ☐Yes ☐No

If Yes, Please Discribe____

Allergies or reactions to any of the following:

☐Yes ☐No Local Anesthetics (Novicaine, Lidocaine, Carbocaine)
☐Yes ☐No Aspirin
☐Yes ☐No Ibuprofen (Motrin, Advil)
☐Yes ☐No Penicillin or other antibiotics Type_______________________________________
☐Yes ☐No Sulfa Drugs
☐Yes ☐No Codeine or other narcotics
☐Yes ☐No Latex products

☐Yes ☐No Are you currently taking or have you ever taken any oral bisphosphonates for Osteoporosis, Osteopenis or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate),Didronel (etidronate)?

☐Yes ☐No Are you currently taking or have you ever taken any intravenous bisphosphates for serious bone disorders/cancers, such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?

Now or in the past, have you had:

☐Yes ☐ No AIDS/HIV
☐Yes ☐ No Anaphylaxis
☐Yes ☐ No Anemia
☐Yes ☐ No Artificial Heart Valves
☐Yes ☐No Artificial Joints
☐Yes ☐ No Atopic (allergy prone)
☐Yes ☐No Asthma
☐Yes ☐ No Back Problems
☐Yes ☐ No Blood Disease
☐Yes ☐No Cancer Type___________
☐Yes ☐No Chemical Dependency
☐Yes ☐No Chemotherapy
☐Yes ☐No Circulatory Problems
☐Yes ☐No Cough (persistent)
☐Yes ☐No Cortisone Treatments
☐Yes ☐No Diabetes
☐Yes ☐No Epilepsy
☐Yes ☐No Fainting
☐Yes ☐No Food Allergies
☐Yes ☐No Glaucoma
☐Yes ☐No Herpes
☐Yes ☐No Heart Murmur
☐Yes ☐No Heart Problems
☐Yes ☐No Headaches
☐Yes ☐No Hemophilia (abnormal bleeding)
☐Yes ☐No Hepatitis Type___________
☐Yes ☐No High Blood Pressure
☐Yes ☐No Jaw Pain
☐Yes ☐No Kidney Disease or Malfunction
☐Yes ☐No Liver Disease
☐Yes ☐No Material Allergies (latex, metals)
☐Yes ☐No Mitral Valve Prolapse
☐Yes ☐No Nervous Problems
☐Yes ☐No Pacemaker/ Heart Surgery
☐Yes ☐No Psychiatric Care
☐Yes ☐No Rapid Weight Gain or Loss
☐Yes ☐No Radiation Treatment
☐Yes ☐No Respiratory Disease
☐Yes ☐No Rheumatic/Scarlet Fever
☐Yes ☐No Shingles
☐Yes ☐No Shortness of Breath
☐Yes ☐No Skin Rash
☐Yes ☐No Spina Bifida
☐Yes ☐No Stroke
☐Yes ☐No Surgical Implant
☐Yes ☐No Swelling of Feet or Ankles
☐Yes ☐No Thyroid Disease or Malfunction
☐Yes ☐No Tobacco Products
☐Yes ☐No Tonsillitis
☐Yes ☐No Tuberculosis
☐Yes ☐No Ulcer/Colitis
☐Yes ☐No Venereal Disease

Women Only:

Are You Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control Pills? ☐Yes ☐No

Please Read and Sign the Following:

I have read and understand to all of the above questions, and will not hold my dentist or any staff member responsible for any errors I have made in the completion of this form. If there are any changes to my health history record I will inform this practice.

Signature____ Date _______________________

Medical History Update:

Comments:____
____
____

Signature____ Date_________________________

Comments:____
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Signature____ Date_________________________

Comments:____
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Signature____ Date_________________________

Comments:____
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Signature____ Date_________________________