Patient Name (Last, First, MI)
____
Dental Record Number________________
Date of Birth (MM/DD/YYYY)________________

University of Minnesota School of Dentistry

Medication List

Physician: Name ________________________________ Phone#______________________________

Address____

Are you under the care of a Specialist: (i.e. Cardiologist, Orthopedic Surgeon, etc.)

Name______________________________ Type_____________ Phone # _______________________

Address____

Reason for today's dental visit____

Date of last dental visit ________________ Did you have x-rays? ______________________________

You may have X-rays from another provider emailed to the School at umortho@umn.edu. Additional x-rays may need to be taken in order to provide a proper diagnosis and to develop an appropriate treatment plan. Non-electronic copies or prints of x-rays are usually not of good diagnostic value.

Dental Office Name ____

Address____

Phone# ______________________________ Fax # ____

I have received bisphosphonate therapy (i.e. Fosamax, Boniva, Actonel, etc.) Yes__ No__
I have received corticosteroid therapy (Prednisone, Betamethasone, etc.) Yes__ No__
I have received IV cancer medication. Yes__ No__

Pharmacy Name_______________________ Phone # ________________ Fax #_________________

Pharmacy Address ____

Patient to fill out prior to visit

Medication Including Homeopathic, Herbal, Dietary supplements, and Recreational Drugs	Dose/Frequency	Condition prescribed for:	Date Started MM/YYYY
(Example) Simvastatin	**20 mg 2 x day**	**High Cholesterol**	**06/2014**