Cha-les A. Mastrovich D.D.S., A P.C.

911 East Grand Avenue
Escondido, CA 92025-3403

LAST NAME ____________ FIRST NAME ____________ INITIAL ______ ©CAM MH-3

The medical information below has been requested for your safety. Your complete answers will assist us in providing for any of your special medical needs during the delivery of dental services.

PLEASE CIRCLE AND / OR FILL IN THE APPROPRIATE ANSWER FOR EACH NUMBER.

1. CIRCLE APPROPRIATE ANSWER (Please leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain: ____________
2. Yes No Has there been a change in your health within the last year?
   If YES, explain: ____________
3. Yes No Have you gone to the hospital, had surgery or a serious illness in the last three years?
   If YES, explain: ____________
4. Yes No Are you being treated by a physician now? If YES, explain
   Date of last medical exam? Reason for exam: ____________
5. Yes No Are you taking any medications or drugs now?
   If yes, please list below:

Drug	Purpose	Dosage and Frequency	1st Prescribed	Prescribing Doctor

2. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)
Fainting spells
Recent significant weight loss or gain
Fever
Night sweats
Persistent cough
Coughing up blood
Bleeding problems
Blood in urine
Blood in stool
Diarrhea or constipation
Frequent urination
Difficulty urinating
Ringing in ears
Headaches
Dizziness
Blurred vision
Bruise easily
Frequent vomiting
Dry mouth
Excessive thirst
Swollen ankles
Joint pain or stiffness
Shortness of breath
Sinus problem

3. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease
Stroke
Heart attack
Heart defects
Heart murmurs
Rheumatic fever
Hardening of the arteries
High blood pressure
Transplants
Pacemaker
Diabetes
Asthma
Emphysema or other lung disease
Kidney or bladder disease
Thyroid disease
Hepatitis
Jaundice
Liver disease
Tuberculosis
Artificial joint
Stomach problems or ulcers
Seizures
Arthritis, rheumatism
Eating disorders
Psychiatric care
Osteoporosis
Eye disease
Blood Disorders
Skin disease
Cosmetic surgery
Tumors or cancer
Chemotherapy
Radiation
AIDS/HIV
Sexually transmitted disease
Herpes
Canker or cold sores

4. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Local Dental Anesthetic
Latex
Nitrous Oxide
Acrylic
Metal
Sulfa
Food
Penicillin
Erythromycin
Tetracycline
Aspirin
Iodine
Advil
Aleve
Codeine
Vicodin
Valium
Keflex
Percodan
Demerol
Darvon
Environmental ______
Other ______

(Please continue on reverse)

MEDICAL HISTORY

I. "Recreational" or "Street" drugs such as cocaine, marijuana, stimulants, or depressants may have severe or even fatal interaction with local anesthetics or other dental medications. Please describe below any use of these drugs, or confidentially discuss with Dr. Mastrovich. ______________________

II. Do you use tobacco products? .... YES NO

- ☐ Smoking: ____ packs per day for approximately ____ years
- ☐ Tobacco (in any form)

III. Do you consume alcoholic beverages? .... YES NO

- ☐ Approximate number of drinks per week: ____

IV. Do you have or have you had any other diseases or medical problems NOT listed on this form? .... YES NO
If YES, explain: ______________________

V. Have you ever been pre-medicated for dental treatment? .... YES NO
If YES, explain: ______________________

VI. Have you ever taken Fen-phen? .... YES NO
If YES, explain: ______________________

VII. Have you taken Bisphosphonates (Fosamax)? .... YES NO

VIII. Are there any issues or conditions that you would like to discuss with Dr. Mastrovich in private? .... YES NO

WOMEN ONLY

IX. Are you or could you be pregnant? .... YES NO
If YES, what month: ____

X. Are you nursing? .... YES NO

XI. Are you taking birth control pills? .... YES NO

RESERVED FOR OFFICE USE

History notes by: ________

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist/staff to contact my physician.

Patient's Signature: ______________________ Date: ____________
Physician's Name: ______________________ Phone Number: ____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medications. Further, 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.

______________________ ______________________

Signature of Patient (Parent or Guardian) Date **Signature of Dentist Date**

Medical Updates: I have reviewed my history above and confirm it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Name:____

Birth date ______________ Email Address:________________

Residence Address: ____________________________________

____

Cell phone: ______________________ Home phone: __________

I am being treated by Dr. Mastrovich for a very specific/ focused area and understand and agree to maintain my annual exams, x-rays, hygiene and general and restorative dentistry with my general dentist and hygienist.

I understand that to fail to do so could lead to dental issues that Dr. Mastrovich is not responsible for, as he is not treating my general dental care.

General dentist under whose care I am ______________________
(Name of General Dentist)

___________________________ Date__________

Patient Signature

Implant Mechanical Rescue (IMR) Introduction and Agreement

Thank you for seeking Dr Mastrovich's care for your implant mechanical rescue. We are dedicated to providing a successful and safe mechanical rescue.

Based on his extensive prior experience, Dr Mastrovich has organized his practice and protocols to support the best possible outcome. Due to the nature of the variable amount of time it takes on each individual case, it is impossible to predict (and schedule) specific completion times. Please understand the following "Protocol For Referral Acceptance":

- Before a patient is actually referred, and before we proceed into retrieval, the referring doctor and Dr. Mastrovich have to understand what happened and whether retrieval is the best option. Full disclosure of what treatment has already been attempted on the case is requested in order to fully evaluate and plan for success.

- IMR Intake Form and radiographs will need to be in our office in advance of the patient being placed on the waiting list for an appointment. This will allow Dr. Mastrovich the time he needs to better evaluate the situation, and optimize the potential for success.

- Dr. Mastrovich frequently finds it necessary to mechanically engineer and fabricate customized tooling to safely retrieve broken parts. This takes time.

- Patients are strongly urged to read Dr. Mastrovich's protocols /view his lecture on his website to better understand the scope and nature of the referral.

- The responsible party for payment of fees will be established before treatment can be scheduled.

Fees have been quoted to me to the best of Dr. Mastrovich's office's ability and I do understand I am responsible for these fees ($860 first hour and $215 for each additional fifteen minute increment). This fee is due and payable (by credit card only) at the time of service.

We do acknowledge dealing with implant failure is disappointing, at best. But please understand we are positioned to help resolve your problem, so your attitude and cooperation are of utmost importance in creating a positive collaboration and a successful outcome.

Please *print* this document, *sign* acknowledging these foundational premises, and *return* it to our office.

____________________	____________________	____________
Signature	Printed Name	Date