HARVEY H. BRECKNER | D.M.D., M.S.

COSMETIC & RECONSTRUCTIVE DENTISTRY

GENERAL DENTIST / FAMILY DENTISTRY

Patient Name:_____ **Date:**_____

Has your Physician instructed you to take antibiotics prior to dental treatment? Yes_____ No_____

If yes, antibiotic _____ and dosage _____reason_____

Are you taking any blood thinners? Yes____ No____

If yes, which one? Plavix _____ Coumadin _____ Other _____

Are you taking Aspirin, Motrin, Aleve or similar pain medication? Yes____ No____

If yes, list type _____ and amount _____

Are you taking Fish Oil? Yes____ No____ **Tumeric?** Yes____ No____ **Melatonin?** Yes____ No____

Please List ALL prescriptions and over the counter medications and the reason for taking them:

Medications / Prescriptions	Dose	Reason for taking