

WELCOME

Patient's Name: _____ Birthdate: _____

Address: _____ City & Zip _____

Home Phone () _____ - _____ Will you receive calls at work? _____

Cell Phone () _____ - _____ Work Telephone () _____ - _____ x _____

E-Mail address _____

Occupation: _____

Employer's Name & Address _____

Social Security Number _____ - _____ - _____

Reason for today's visit: Checkup _____ Problem/Pain _____ Other _____

Whom may we thank for referring you to our office? _____

Please answer the following questions:

1. Name & telephone of physician _____

2. Date of last visit to doctor _____

Purpose of visit _____

3. Date of last visit to dentist _____

Purpose of visit _____

Note: There are drugs and medications used in routine dental care that are incompatible with several drugs. The effect of the combination could be dangerous to your health.

4. Are you currently taking any drugs, prescriptions or recreational? _____

If yes, what drug and when _____

5. Do you have any allergies? _____

PLEASE CONTINUE ON OTHER SIDE

Circle yes or no to the following conditions Current or Previous:

Blood pressure & heart problems: pace maker-----	yes	no
Rheumatic fever or heart murmur -----	yes	no
Mitral Valve prolapse-----	yes	no
Hepatitis or liver problems-----	yes	no
Diabetes or kidney problems-----	yes	no
Aids – Acquired immune deficiency syndrome-----	yes	no
Excessive bleeding or trouble healing-----	yes	no
Tuberculosis-----	yes	no
X-ray treatment or chemotherapy-----	yes	no
Fainting or seizures-----	yes	no
Artificial or replacement joints, prosthetic-----	yes	no

7. Do you use tobacco products? _____

8. Do you use alcohol products? _____

9. Women please answer the following:

Are you pregnant----- yes no

Are you taking birth control or hormone therapy----- yes no

Have you had a mammogram----- yes no

10. Is there anything you would like us to know about your previous dental appointments? _____

Emergency notification:

Name: _____ Telephone: _____

Relationship to patient _____

Permission to release health information:

I grant the right to Dr. Patrice Foudy to release health information obtained from me and information about my dental treatment to third party payors and for other health care practitioners.

Print Name _____ Signature _____

If other than patient relationship _____

Witness _____ Date _____