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_____