W. ROBERT PRICE, D.D.S., PA

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PATIENT INFORMATION & MEDICAL HISTORY

NAME: _____ Date: _____

Reason for your visit:_____
Are you having discomfort or pain? _____ If so, how long? _____
Address: _____ City: _____
Zip: _____ Home Phone: _____ Social Security Number: _____
Occupation: _____ What Company: _____
Work Phone: _____ Extension: _____ Date of Birth: _____
Dental Insurance Company: _____
Name of nearest relative or friend in case of emergency: _____
Emergency Phone: _____
Who recommended you to our office? _____
Name of your Physician: _____ Physician Phone: _____

Check Any That Apply

- ❑ Congenital Heart Defect
- ❑ Mitral Valve Prolapse (Leaky Valve)
- ❑ Artificial Heart Valve
- ❑ Heart Surgery
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Pacemaker
- ❑ Artificial Joints
- ❑ Heart Attack
- ❑ Tire easy, weakness
- ❑ Marked weight change
- ❑ Night sweats
- ❑ Chest Pain
- ❑ High blood Press.
- ❑ Short of breath
- ❑ Dizziness Fainting
- ❑ Sputum – Phlegm
- ❑ Persistent Cough
- ❑ Arthritis
- ❑ Diabetes
- ❑ Psychiatric Treatment
- ❑ Are You A Smoker _____ Packs/Day
- ❑ Kidney Disease
- ❑ Dialysis treatment
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Hives
- ❑ Change in skin color
- ❑ Anemia
- ❑ Visual change
- ❑ Glaucoma
- ❑ Hearing Loss
- ❑ Ringing in ears
- ❑ Frequent nose bleeds
- ❑ Sinus Problems
- ❑ Asthma – Hay Fever
- ❑ Epilepsy
- ❑ Cancer
- ❑ Tumors or Growths
- ❑ Radiation Therapy
- ❑ AIDS – HIV
- ❑ Pregnant
  What trimester? 1 2 3

ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

- ❑ Local anesthetic (Novocaine)
- ❑ Aspirin
- ❑ Codeine
- ❑ Barbiturates / Sedatives
- ❑ Sulfa drugs
- ❑ Penicillin
- ❑ Other antibiotics
- ❑ Other allergies

ARE YOU NOW TAKING ANY OF THE FOLLOWING:

- ❑ Antibiotics/sulfa drugs
- ❑ Tranquilizers
- ❑ Blood thinners
- ❑ Insulin/diabetic drugs
- ❑ Blood Pressure medication
- ❑ Recreational drugs
- ❑ Thyroid medication
- ❑ Digitalis
- ❑ Cortisone/steroids
- ❑ Heart--Medications
- ❑ Antihistamines/allergy drugs
- ❑ Nitroglycerin
- ❑ Cold remedies
- ❑ Aspirin

If you answered **YES** to any of the above, list NAME of medication and DOSAGE below:

_____

_____

_____

Is there any disease or condition or problem **NOT** listed above that you think we should-know about. Is there any activity your doctor says you cannot do? If so explain:

_____

_____

Have you ever had any serious trouble associated with previous dental treatment? Yes No

_____

Does dental treatment make you nervous? Circle the best answer. **No Slightly Moderately Extremely**

Approximate date of last dental visit: _____

Have you ever been treated for periodontal or gum disease? _____
If so - when: _____

Signed:_____

Unpaid balances are subject to a billing charge of 1-1/2% per month of the balance over 90 days.