Patient Information

Name: ____ Male ☐ Female ☐
Last First M.I

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: ____

City:____ State: _______ Zip: ___________

Home Phone: (_____) _________________________ Work Phone: (_____) ______________________

Cell Phone: (_____) ___________________________

Email Address: ____

Person to Contact in Case of an Emergency: _____________________________________

Cell Phone: (_____) ______________________ Home Phone: (_____) ___________________________

Parent Or Guardian Of Patient (If Patient Is Under 18 Years Of Age)

Name: ____
Last First M.I.

Relationship To Patient: ____

Address: ____

City:____ State: _______ Zip: ___________

Home Phone: (_____) _________________________ Work Phone: (_____) ______________________

Cell Phone: (_____) ___________________________

If you are completing this form for another person, your relationship to that person is?____________________________ Your answers to the following questions are for our records only and are considered confidential. You may be questioned during your visit on your response to the questions you answered.

1. Are you in Good health?.. Yes No
2. Have there been changes in your general health in the past year?.. Yes No
3. Have you had any serious illness, operation, or been hospitalized in the past 5 years? …………………. Yes No
Please explain: ____
4. List any medications – prescription or non-prescription that you are currently taking: ___________________
5. Are you on Aspirin Therapy?.. Yes No
6. Are you on Vitamin E Therapy?... Yes No
7. Do you smoke?.. Yes No
If yes, how long have you smoked? _______________ How many packs per day? _______________
8. Do you have a family history of periodontal disease?.. Yes No
Do you have or had any of the following diseases or problems:
9. Damaged or artificial heart valves?.. Yes No
10. Heart murmur or rheumatic heart disease?.. Yes No
11. Cardiovascular disease (heart trouble, heart attack, angina, coronary, insufficiency, coronary occlusion, stroke or arteriosclerosis?.. Yes No
12. High Blood Pressure?... Yes No
13. Low blood pressure?.. Yes No
14. Chest pain?.. Yes No
15. Shortness of breath after mild exercise or when lying down?.. Yes No
16. Heart defects?.. Yes No
17. Cardiac pacemaker?.. Yes No
18. Seasonal Allergies?.. Yes No
19. Sinus trouble?.. Yes No
20. Asthma or hay fever?... Yes No
21. Fainting or seizures?.. Yes No
22. Diabetes? ……………………………………………………………………………......………Yes No
23. Hepatitis or liver disease?... Yes No
24. Aids or HIV infection?.. Yes No
25. Thyroid problems?... Yes No
26. Respiratory problems, emphysema, bronchitis etc?.. Yes No
27. Arthritis or painful swollen joints?... Yes No
28. Stomach ulcer or hyperacidity?.. Yes No
29. Kidney trouble?.. Yes No
30. Tuberculosis?... Yes No
31. Persistent cough, cough that produces blood or persistent swollen glands in neck? ……….…................... Yes No

32. Sexually transmitted disease?.. Yes No
33. Epilepsy?.. Yes No
34. Problems with mental health?... Yes No
35. Cancer?.. Yes No
What Type? ______________________________ Treatment Received? ________________________________
36. Abnormal bleeding?.. Yes No
37. Blood disorder such as anemia?... Yes No

Are you allergic or have you had a reaction to:

38. Latex Allergy?.. Yes No
39. Local anesthetic?... Yes No
40. Penicillin or other antibiotics?... Yes No
41. Sulfa drugs?... Yes No
42. Aspirin?... Yes No
43. Iodine?.. Yes No
44. Codeine or other narcotics?... Yes No
45. Other: ____
46. Do you have any disease, conditions, or problems not listed you think I should know about? ……...…..Yes No
47. Are you wearing contact lenses?.. Yes No
48. Are you wearing removable dental appliances?... Yes No
Women
49. Are you pregnant?.. Yes No
50. Are you nursing?... Yes No
51. Are you taking birth control pills?... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. 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.

Patient or Guardian Signature : _________________________________ Date : __________________

* Thank you for choosing Barrington Road Dental Care to serve your dental needs. We are delighted that you will be joining our family of happy and satisfied patients. We look forward to meeting you. *