Reese Family Dentistry

Patient name _____ D/O/B _____

Physicians name _____ Phys. Phone Number_____

Medications (if any) _____

Allergies (if any) _____

Please mark appropriate answer

Heart Disease- Y N
Pacemaker- Y N
Artificial heart valve- Y N
Rheumatic fever- Y N
Heart murmurs- Y N
High blood pressure- Y N
Serious illness- Y N
Major surgery- Y N
Chemotherapy- Y N
Arthritis- Y N
Rheumatism- Y N
Artificial joints- Y N
Anemia- Y N
Excessive bleeding- Y N
Stomach problems- Y N
Kidney problems- Y N
Liver problems- Y N
Diabetic- Y N
Asthma- Y N
Epilepsy- Y N
Venereal disease- Y N
HIV positive- Y N
AIDS- Y N
Hepatitis- Y N
Psychiatric treatment- Y N

_____
(Type of Surgery)

Smoke- Y N
If yes, how much? _____
Alcohol- Y N
If yes, how much? _____

Canker sores- Y N

For Women

Pregnant- Y N

Birth Control - Y N

Do you like the way your teeth look? Y N

Do you wish your teeth were whiter? Y N

May we contact your other healthcare providers? Y N

Do you have any concerns you like to discuss? Y N

Would you like to speak with the Doctor privately? Y N

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signed _____ Date _____