_DATE____

Dr. Eric McDonough DMD MEADOW DENTAL CENTER

NAME				DA	ATE OF BI	IRTH		MAL	E F	FEMALE	
STREET				CIT	Y	STATE	·	ZIP_			
HOME PHON	NE ()	C1	ELL PHON	TE()_	V	VORK ()			
Text message	remin	ders? YES	NO	E-mail r	eminders?	YES NO					
SOCIAL SECURITY # EMPLOYER/SCHOOL											
DENTAL INSU	JRANC	EE CO					_ (please p	provide car	d for p	photocopy)	
				DATE OF BIRTH					MALE FEMALE		
						ST.					
					_ 0111	511					
SOCIAL SECURITY # EMPLOYER/SCHOOL											
EMERGENCY CONTACT: NAMEPHONE ()											
Are you under t	the care	of a physician?	(Dr		for	:)		YES	NO	
Are you taking	any me	dication? Please	e list:							_	
Are you allergic to anything? (Penicillin, Codeine, Acrylic, Metal, Latex, other)									YES	NO	
Have you ever been hospitalized? Please explain:									YES	NO	
Have you ever had a serious injury to your head or neck? WOMEN (Circle all that apply) Pregnant - Possibly pregnant - Nursing - Taking oral co									YES	NO	
WOMEN (Circ	cle all tl	hat apply) Pres	gnant -	Possibly pr	egnant -	Nursing - Tak	ing oral c	ontracept	ives		
Are you allergic to any anesthetics? YES NO Do you wish to talk to the dentist privately about any problems? YES NO											
						YES NO Yes or No next to	each iten	1			
•		•		C							
Heart trouble Heart murmurr	Yes No Yes No	bruise easily chemotherapy	Yes No Yes No	emphysema tuberculosis	Yes No Yes No	kidney problems renal dialvsis	Yes No Yes No	fever blisters herpes		Yes No Yes No	
Irregular heart beat	Yes No	excessive bleeding	Yes No	cancer sickle cell	Yes No	renal dialysis thyroid disease	Yes No	stroke		Yes No	
Chest pain Heart attack/failure	Yes No Yes No	radiation treatment hemophilia	Yes No Yes No	sickle cell anemia	Yes No Yes No	parathyroid disease arthritis/gout	Yes No Yes No	convulsions hepatitis		Yes No Yes No	
Congenital heart disorder		blood transfusion	Yes No	stomach disease		rheumatism	Yes No	cold sores		Yes No	
Mitral valve prolapse	Yes No	leukemia	Yes No	ulcers	Yes No	psychiatric care	Yes No	glaucoma		Yes No	
Scarlet fever Rheumatic fever	Yes No Yes No	swelling limbs lung disease	Yes No Yes No	weight loss diarrhea	Yes No Yes No	cortisone medicine artificial joint	Yes No Yes No	asthma nervousness		Yes No Yes No	
Artificial heart valve	Yes No	breathing problems	Yes No	diabetes	Yes No	venereal disease	Yes No	jaw pain		Yes No	
Pacemaker	Yes No	shortness of breath	Yes No	excessive thirst	Yes No	Alzheimer's disease	Yes No Yes No	AIDS		Yes No	
Heart surgery High blood pressure	Yes No Yes No	frequent cough hay fever	Yes No Yes No	hypoglycemia liver disease	Yes No Yes No	HIV positive genital herpes	Yes No	allergies hives/rash		Yes No Yes No	
Low blood pressure	Yes No	sinus trouble	Yes No	epilepsy/seizures	Yes No	drug addiction	Yes No	osteoporosis		Yes No	
Blood disease	Yes No	tumors/growths	Yes No	yellow jaundice	Yes No	fainting/dizziness	Yes No				
Do you snore?									YES	NO	
Do you feel rested in the morning? Please explain:									YES	NO	
									YES	NO	
Do you use any tobacco product?								·	YES	NO	
									YES	NO	
Do you like your smile? Please explain: Do you have: Sensitive Teeth Bleeding Gums Sore Jaw											
Have you had a bad dental experience? Please explain:									YES	NO	
Who can we	thank fo	or referring you?									
I have read ever	rything	on this form and	l have ar	swered corr	ectly to the	best of my know	vledge.				

SIGNATURE_____