WEST MOBILE DENTAL CARE

All information provided here is kept completely confidential, thus any attempt to conceal pre-existing conditions or other relevant information could result in drug interactions, allergies, or treatment complications. The following questions must be answered honestly so that our office can provide you with the best possible care and service. Thank you for your understanding in this matter.

Please indicate your response by placing a checkmark in the appropriate column.	Yes	No
Have you ever been seriously ill?		
Have there been any changes in your general health recently?		
Is a medical doctor currently treating you?		

Please provide your medical Dr.'s name and phone number.

_____

Please list all medication(s) (Prescription or Over-the-Counter) that you take:

_____

_____

Have you ever had a major operation or been hospitalized?		

If yes, please specify_____

Have you had a physical exam within the last year?		
Have you ever had to take antibiotics before having dental work?		
Do you have artificial joints, heart valves, or an organ transplant?		
Do you have chest pains upon exertion?		
Have you ever had x-rays for a tumor, growth, or other condition?		
Are you allergic to, or have you had unusual reactions to any of the following? If Yes, circle all that apply: Penicillin - Aspirin - Iodine - Codeine - Latex - Erythromycin - Sulfa Drugs - Barbiturates Other_____		
Have you ever been exposed to the AIDS Virus (HIV)?		
Are you currently using any recreational drugs such as marijuana or cocaine?		
Have you ever taken the drug Phen-Phen?		
Have you ever had a blood transfusion?		
Have you ever experienced an unusual reaction to dental anesthetic?		

_____ _____ _____

Patient Name (Please Print) Patient | Parent or Guardian Signature Date