PATIENT

First Name:_____Last Name:_____

MEMBER

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Postal Code:_____ Country:_____

E-mail Address:_____

Home Number: _____ Cell Phone Number: _____

Job:_____ Unit:_____

Health Insurance Provider:_____

In the interest of a complication-free treatment, please provide the following information:

1. Do you suffer from cardiovascular diseases? Yes ☐ No☐
2. Do you have difficulty breathing sometimes? Yes ☐ No ☐
3. Do you take blood-thinning medication? Yes ☐ No ☐
4. Are you a diabetic? Yes ☐ No ☐
5. Are you currently taking medication? Yes ☐ No ☐
   If so, what medication?_____
6. Are you suffering from an infectious disease (Hepatitis, AIDS, etc.) ? Yes ☐ No ☐
7. Do you have allergies? Yes ☐ No ☐
   If so, what allergies?_____
8. Do you have any other disease? Yes ☐ No ☐

Dental History

1. Do you sometimes have bleeding gums? Yes ☐ No ☐
2. Ever have an incident during a dental treatment? Yes ☐ No ☐
3. Would you prefer a treatment under local anesthesia? Yes ☐ No ☐
4. Do you want information on ways to prevent tooth decay and gum disease? Yes ☐ No ☐
5. When were your teeth last X-rayed? _____
6. Recommended/ referred by: _____

Note: If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. For not timely cancelling your appointment we have to charge you a cancellation fee.

Date:_____ Signature:_____