Patient Information

Patient Name: ______________________ Date: ______________________

Email Address: ______________________ Phone #: ______________________

Are you having any dental problems? ☐ Yes ☐ No
Have you had any complications following dental treatment? ☐ Yes ☐ No
Have you ever had a reaction to local anesthetic? ☐ Yes ☐ No

When was your last dental cleaning? ______________________ ***Last X-rays***: ______________________

Are you taking any medication? ☐ Yes ☐ No If yes, please list.

1.______________________ 3.______________________ 5.______________________

2.______________________ 4.______________________ 6.______________________

Name of Physician MD: ______________________ **Phone #**: ______________________

Have you ever been told you need antibiotics before a dental cleaning? ☐ Yes ☐ No

Have you ever had one of the following?

☐ Yes ☐ No AIDS
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Joints
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cancer
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Excessive Bleeding
☐ Yes ☐ No Fainting

☐ Yes ☐ No Sleep Apnea
☐ Yes ☐ No Are you Pregnant?
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Heart Valves/Transplant
☐ Yes ☐ No Heart Transplant
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Alzheimer's/Dementia
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Low Blood Pressure

☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Tumors
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcers

ALLERGIES:

☐ Yes ☐ No Codeine
☐ Yes ☐ No Amoxicillin
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Sulfa
☐ Yes ☐ No Latex
☐ Yes ☐ No Other

If yes, please list: ______________________
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Signature of Patient, Parent, or Guardian Date

Ryan A. Starr DMD _______ Initials