

DAVID E. BURNS • DAVID A. BURNS

Welcome to Our Office,

To aid in your dental treatment, please provide the following personal medical and dental information for our records. Please fill in the following questionnaire. If there are any questions about the form, our receptionist will be happy to assist you.

Patient's Name _____ Date of Birth _____ Age _____

SS# _____ Marital Status _____ Responsible Party _____

Address _____ City/State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Employer _____ Business Phone (____) _____

Spouse Employed _____ Business Phone (____) _____

Email _____ Contact Preference _____

Purpose of Visit _____

Who referred you to our office? _____

MEDICAL AND DENTAL HISTORY

Date of Last Dental Exam _____ Dentist's Name _____ Phone # _____ Address _____

Date of Last Medical Exam _____ Physician's Name _____ Phone # _____ Address _____

Have you ever had or do you have any of the following: Please Circle If Necessary

- Yes No – Asthma
- Yes No – Diabetes
- Yes No – Epilepsy
- Yes No – Liver Problems
- Yes No – Lung Problems
- Yes No – Kidney Problems
- Yes No – Rheumatic Fever
- Yes No – Cardiovascular Disease
(Heart Trouble/Heart Attack/Coronary/Murmur/Stints/etc)
- Yes No – High/Low Blood Pressure
- Yes No – History of Fainting
- Yes No – HIV
- Yes No – Hepatitis A/B/C
- Yes No – STD's
- Yes No – Are you Pregnant?
- Yes No – Joint Replacements
- Yes No – Prolonged Illness _____

If you answer yes to the following questions please list and explain.

Any serious problem/abnormal bleeding associated with previous dental treatment? _____

Have you had any adverse or allergic response to any drugs or anesthetic? _____

Are you taking any medications at present time? _____

Are you under medical care at present time? _____

Any other illnesses: past or present? _____

Do you use controlled substances? _____

Describe your general Health in a few words. _____

Patient or Parent Signature _____ Date _____