Friendly City Dental
T: (540) 433-3080 *F: (540)433-1066*
www.friendlycitydental.com

Patient Name: _____
LAST **FIRST** **MIDDLE**

Gender: ( ) MALE ( ) FEMALE **Marital Status**: ( ) Married ( ) Single ( ) Child ( ) Other: _____
Social Security #: _____ / _____ / _____ **Date of Birth:** _____ - _____ - _____
Address: _____ **City, State:** _____ **Zip Code:** _____
Phone (Cell #1): _____ **(Cell #2):** _____
Employer: _____ **Work#:** _____
Email: _____ **Emergency Contact#/Relation:** _____

Medical History

Reason for Visit/Area of Concern: _____ **Date of Last Dental Visit:** _____

Have you even been prescribed a blood thinner or bone density medication? (Fosamax/Plavix/Coumadin/Aspirin) **YES/ NO**
Are you **ALLERGIC** to: Aspirin/Penicillin/Codeine/Latex/Local Anesthetic/Other: _____ **YES/ NO**
Have you ever had any complications following dental treatment? **YES**, explain: _____ **YES/ NO**
Have you been admitted to the hospital or needed emergency care in the past two years? _____ **YES/ NO**
Explain: _____
Are you under the care of a physician now? **YES**, explain: _____ **YES/ NO**
Name of Physician: _____ Office Name: _____ Phone #: _____
Do you have any **HEART PROBLEMS**: **YES**, explain: _____ **YES/ NO**
Have you ever been told you needed **PRE-MEDICATION** (antibiotic): _____ **YES/ NO**

FEMALES-Are you or could be PREGNANT at this time? **YES, DUE DATE:** **Trimester: 1st 2nd 3rd** **YES/ NO**

Please check **ALL** that apply:

( ) AIDS/ HIV (circle)
( ) Allergies: _____
_____
( ) Anemia
( ) Artificial Joints
( ) Asthma
( ) Blood Disease
( ) Cancer
( ) Diabetes Type I or II
( ) Dizziness
( ) Epilepsy
( ) Excessive Bleeding
( ) Fainting
( ) Glaucoma (Acute / Open)
( ) Hay Fever
( ) Heart Murmur
( ) Hepatitis A/ B/ C
( ) High or Low Blood Pressure
( ) Kidney Disease
( ) Liver Disease
( ) Mental Disorders
( ) Nervous Disorders
( ) Pacemaker
( ) Radiation Treatment
( ) Respiratory Problems
( ) Rheumatoid Arthritis
( ) Sinus Problems
( ) Stomach Problems
( ) Stroke
( ) Tobacco Use
( ) Tuberculosis
( ) Tumors
( ) Ulcers
( ) OTHER:
_____
_____
_____

( )***NONE***

Are you currently taking any medications? ( )*NONE*** If **YES**, please list:**
_____
_____

To the best of my knowledge, all of the preceding answers and the information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

X _____

Signature of Patient (If patient is a minor, Parent or Guardian) Date