dentistry from the heart

Registration

(Please Print Clearly)

Date: _____ #_____

Patient Name: _____ Birth Date: _____
Address: _____
_____

Phone: _____ SS#: _____

Guardian/Parent (if patient is a minor) _____

Do you have or have you ever had:

	Yes	No
Abnormal Bleeding	_____	_____
Abnormal Heart Condition	_____	_____
Artificial Joints	_____	_____
Mitral Valve Prolapse	_____	_____
Heart Murmur	_____	_____
Hepatitis	_____	_____
HIV/AIDS	_____	_____
Rheumatic Fever	_____	_____

Are you allergic to Latex? Yes _____ No _____
Are you allergic to Penicillin? Yes _____ No _____

Are you allergic to any other drugs or medications? If so, please list:

_____

Please list any other physical conditions we should know about: _____

_____

_____

Chief Complaint: _____

Circle one of the following procedures:

A. Filling
B. Extraction
C. Hygiene Cleaning


smile. it's free.