RONALD J. TOSCH D·D·S SM

Yes No

√ yes or no if you are allergic to:

___ ___ Penicillin
___ ___ Codeine
___ ___ Local Anesthetics
___ ___ Latex Products
___ ___ Other Drugs/Materials

Yes No

√ yes or no if you have ever had:

___ ___ Difficulty opening your mouth
___ ___ Pain in region of ears
___ ___ Excessive bleeding from cuts
___ ___ Bleeding gums
___ ___ Arthritis
___ ___ Chronic Sinus
___ ___ Epilepsy
___ ___ Malignancies
___ ___ Chemo/Radiation Treatment
___ ___ Slow healing from cuts
___ ___ Gonorrhea
___ ___ Herpes
___ ___ Syphilis
___ ___ Heart Problems
___ ___ Angina
___ ___ Heart Murmur
___ ___ High Blood Pressure
___ ___ Asthma
___ ___ Diabetes: Insulin Dependent
___ ___ Diabetes: Non-Insulin Dependent
___ ___ Rheumatic Fever
___ ___ Hepatitis
___ ___ Jaundice
___ ___ Tuberculosis
___ ___ AIDS
___ ___ HIV+
___ ___ Artificial Body Part or Replacement
___ ___ Do you use tobacco?
___ ___ Have you ever taken the Prescription diet pill Phen-Phen or Redux? If yes, how long ago?

_____
_____

Reviewed with patient/parent
By_____on_____
Blood Pressure____/____ Pulse____

Yes No

√ yes or no if your mouth is sensitive to:

___ ___ Heat
___ ___ Cold
___ ___ Sweets
___ ___ Biting
___ ___ Chewing
___ ___ Previous Injury:

_____

Please list all prescriptions and/or over-the-counter medications you are currently taking:

_____
_____
_____

Is there any other medical condition we should be aware of? _____

Does your physician recommend pre-medication with antibiotics before dental work?

_____

Women: Are you pregnant? _____
If yes, how many months? _____
Are you taking birth control pills? ____

Who referred you to our office? _____
Former Dentist _____
Date of last dental exam _____
Date of last dental x-rays _____
What is your main dental complaint? _____

_____
Purpose of this appointment_____

_____
Are you apprehensive about dental appointments? _____
Name of person to contact in case of emergency _____
Relationship to patient _____
Home Phone_____ Work Phone_____
Name of Physician_____
Physician's Phone_____

I hereby state that the information on this form is true and correct to the best of my knowledge.

Signature_____
Date_____ Relationship to patient_____