Ronald J. Tosch, DDS

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 (cold sores)
___ ___ 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?
___ ___ Had COVID?
___ ___ Have you ever taken Boniva, Fosamax (or a similar Rx) containing **Bisphosphonates?**

Reviewed with patient/parent
By___________ on_______

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 # ________________ Cell # _____________
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 _______