GLENWOOD Meadows DENTAL

BENJAMIN COON, DDS

PERSONALIZED, COMFORTABLE CARE

Patient Information

Today's Date: _____ Patient Name: _____ DOB: _____
Home address: _____ SSN: _____
Mailing Address:_____City:_____State:_____Zip:_____
Home: _____Cell: _____ Work:_____
Employer: _____ Employer Address: _____
Employer Phone: _____
Email: _____
Whom may we thank for referring you: _____
Preferred Method of Contact: Call___ Text___ Email_____

Emergency Contact Name: _____
Phone: _____ Relationship to you: _____

Medical History

Physician's Name_____ Physician's Phone _____Date of last exam_____

		Yes	No
1.	Are you currently under medical treatment	□	□
2.	Have you ever been hospitalized for any surgical Operation or serious illness?	□	□
3.	Are you currently taking any medication(s) including Non-prescription medicine? If yes, please list all medications:	□	□
4.	Do you use tobacco	□	□
5.	Do you use alcohol or other drugs	□	□
6.	Are you allergic to or have had any reactions to any drugs or latex? If yes, please specify.	□	□
7.	**Women only:**		
	A) Are you pregnant or think you may be pregnant?	□	□
	B) Are you nursing?	□	□
	C) Are you taking birth control pills?	□	□

_____

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8. Please indicate which of the following applies to you. Check only if the answer is yes.

__ High Blood Pressure	**__ Heart Disease**	**__ Chest Pains**
__ Kidney Diseases	**__ Asthma**	**__ Cardiac Pacemaker**
__ Heart Murmur	**__ Stroke**	**__ Rheumatic Fever**
__ Anemia	**__ Hepatitis**	**__ Swollen Ankles**
__ Sinus Problems	**__ Fainting/ Seizures**	**__ Stomach Ulcers**

__ Diabetes **__ Arthritis** **__ Tumors**
__ Respiratory Problems **__ Liver Disease** **__ Radiation Therapy**
__ Low Blood Pressure **__ Cancer** **__ Heart Attack**
__ Chemotherapy **__ Bisphosphonate Therapy** **__ AIDS or HIV**
__ Angina **__ Epilepsy** **__Bleeding Disorder**
__ Leukemia **__ Osteoporosis**

□Other _____

Patient Dental History

Please check if you have any of the following:

__Dental Pain **__Loose Teeth** **__Bleeding Gums**
__Ulcers or Lumps in Mouth **__Clenching** **__Grinding**
__Hot/Cold Sensitivity **__Halitosis** **__Jaw Pain**
__Limited Opening **__Orthodontic Care**
__Prolonged Bleeding Following Dental Extractions

Date of Last Dental Visit: _____ Office Name:_____

Other dental
concerns:_____

X_____
Patient, Parent or Guardian Signature Date

X_____
Dentist signature Date

*__I certify that I have read and understand the above information, to the best of my knowledge; the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.__