Deborah Manos, DDS, MS, FAGD, PLLC — **Patient Information & Medical History**

Patient Name: _____ Date: _____
Address: _____ Date of Birth: _____
_____ Home Ph #: _____
E-Mail: _____ Cell Ph #: _____
How would you like us to confirm your appointments? Work Ph #: _____
□ *postcard* □ *e-mail* □ *phone call* SS #: _____

Patient Medical History

Physician: _____
Office Phone #: _____
Date of Last Exam: _____

1. Are you under medical treatment now? □ Yes □ No
If yes, for what? _____
2. Have you ever been hospitalized for any surgical operation or serious illness? □ Yes □ No
3. Do you use tobacco? □ Yes □ No
4. Do you use alcohol? □ Yes □ No
5. Do you wear contact lenses? □ Yes □ No
6. *Women Only*:
   a.) Are you pregnant? □ Yes □ No Week # _____
   b.) Are you nursing? □ Yes □ No
   c.) Are you taking birth control pills? □ Yes □ No

Do you have or have you had any of the following?

□ Heart Attack	□ High / Low Blood Pressure
□ Rheumatic Fever	□ Stroke
□ Mitral Valve Prolapse	□ Asthma
□ Heart Disease	□ Epilepsy / Seizures / Fainting
□ Angina / Chest Pains	□ Diabetes
□ Heart Murmur	□ HIV / AIDS
□ Artificial Heart Valves	□ Drug / Alcohol Abuse
□ Cardiac Pacemaker	□ Kidney Diseases
□ Leukemia	□ Emphysema
□ Cancer / Chemotherapy	□ Radiation Therapy
□ Hepatitis / Jaundice	□ Joint Replacement or Implant
□ STD	□ Ulcers / Colitis
□ Swollen Ankles	□ Severe / Frequent Headaches
□ Tuberculosis	□ Arthritis
□ Glaucoma	□ Liver Disease
□ Sinus Problems	□ Respiratory Problems
□ Fever Blisters	□ Hemophilia/Abnormal Bleeding
□ Blood Transfusion	□ Thyroid Problem

□ Other: _____

In the event of an emergency, is there someone who lives near you that we should contact?
Name & Relation: _____
Home #: _____ Cell/Wk #: _____

Allergies and Medications

Are you currently taking any medication(s) including prescription & non-prescription medicine? □Yes □No
If Yes, what medications are you taking?
_____
_____
_____

Do you need to take antibiotic premedication?
□ Yes □ No

Are you allergic to or have you had any reactions to any of the following?
Local Anesthetics (i.e. Novocaine) □ Yes □ No
Latex □ Yes □ No
Sulfa Drugs □ Yes □ No
Barbiturates □ Yes □ No
Sedatives □ Yes □ No
Iodine □ Yes □ No
Aspirin □ Yes □ No
Codeine □ Yes □ No
Penicillin or other antibiotics □ Yes □ No
If yes, what type:_____
Other allergies not listed above: _____
_____
_____

Insurance Benefits: Have you had any changes to your dental benefits since your last visit? □ Yes □ No

Comments: _____
_____
_____
_____

I certify that I have read and understand this information to the best of my knowledge and that the questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

Signature: _____

Date: _____