Welcome

Life gets better with each smile.

AestheticDentistry
OF STUART

Amy Crary, D.M.D.

Please take a few minutes to answer the following questions so we can better assist you.

Guest Information

TODAY'S DATE ______ BIRTH DATE ______ SOCIAL SECURITY# ______

(GUEST) LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______

STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

OCCUPATION ______ ◯ MALE ◯ FEMALE ◯ SINGLE ◯ MARRIED ◯ WIDOWED

HOME PHONE ______ CELL PHONE ______

E-MAIL ______ WORK PHONE ______

EMPLOYER ______

In case of emergency contact:

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______

NAME ______ RELATIONSHIP ______

EMERGENCY HOME PHONE ______ EMERGENCY WORK PHONE ______

Primary Dental Insurance (or provide copy of ID card)

(INDIVIDUAL RESPONSIBLE FOR THIS ACCOUNT) LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______

RELATIONSHIP TO GUEST ______ BIRTH DATE ______ SOCIAL SECURITY# ______

STREET ADDRESS ______ HOME PHONE ______

CITY ______ STATE ______ ZIP CODE ______

RESPONSIBLE PARTY EMPLOYED BY ______ WORK PHONE ______

INSURANCE COMPANY ______

INSURANCE COMPANY ADDRESS ______ INSURANCE COMPANY PHONE # ______

SUBSCRIBER I.D. # ______ GROUP# ______

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Check any symptom(s) or condition(s) below that you currently have or have had in the past.

- ◯ HIGH BLOOD PRESSURE
- ◯ HEART MURMUR
- ◯ MITRAL VALVE PROLAPSE
- ◯ ARTIFICIAL HEART VALVE
- ◯ CARDIAC PACEMAKER
- ◯ CARDIOVASCULAR DISEASE, HEART ATTACK, STROKE OR BYPASS
- ◯ ANGINA, CHEST PAIN
- ◯ CONGENITAL HEART DISEASE
- ◯ IRREGULAR HEARTBEAT
- ◯ LOW BLOOD PRESSURE
- ◯ ARTHRITIS
- ◯ ARTIFICIAL JOINTS (KNEE, HIP, ETC.)
- ◯ ASTHMA
- ◯ HAY FEVER OR SINUS PROBLEMS
- ◯ BLEEDING DISORDER (ANEMIA, HEMOPHILIA, ETC.)
- ◯ EMPHYSEMA
- ◯ TUBERCULOSIS
- ◯ BRONCHITIS, CHRONIC COUGH
- ◯ DIABETES
- ◯ LOW BLOOD SUGAR
- ◯ STOMACH ULCERS, COLITIS
- ◯ KIDNEY DISEASE
- ◯ LIVER DISEASE
- ◯ JAUNDICE
- ◯ HEPATITIS (TYPE ______)
- ◯ EPILEPSY OR SEIZURES
- ◯ DEMENTIA OR ALZHEIMER'S
- ◯ FAINTING SPELLS
- ◯ NEUROLOGICAL CONDITION (MULTIPLE SCLEROSIS, PARKINSON'S, ETC)
- ◯ THYROID DISEASE
- ◯ EYE DISEASE OR GLAUCOMA
- ◯ HEARING LOSS
- ◯ HIV/AIDS
- ◯ SEXUALLY TRANSMITTED INFECTION
- ◯ CONTAGIOUS DISEASES
- ◯ HERPES OR COLD SORES
- ◯ CANCER
  IF YES WHAT TYPE? ______
- ◯ PSYCHIATRIC PROBLEMS
- ◯ DEPRESSION, ANXIETY
- ◯ HISTORY OF ALCOHOL OR DRUG ABUSE
- ◯ HEADACHES, MIGRAINES

Questions

Have you ever been advised to take **antibiotic** premedication prior to **routine dental work**? ◯ YES ◯ NO

If yes, give reason and antibiotic used ______

Have you ever had surgery and/or radiation for a tumor, growth, or other condition? ◯ YES ◯ NO

Have you ever had abnormal bleeding following extractions or surgery? ◯ YES ◯ NO

Are you currently taking or have you taken **bisphosphonate medication**, such as Actonel, Reclast, or Fosamax within the past twelve years? ◯ YES ◯ NO

If yes, give names and dates ______

Women only: Is there a possibility that you are pregnant? ◯ YES ◯ NO

Are you nursing? ◯ YES ◯ NO

Allergies

- ◯ PENICILLIN
- ◯ CODEINE
- ◯ ASPIRIN
- ◯ NSAIDs (ADVIL, ALEVE, ETC.)
- ◯ LATEX
- ◯ DENTAL ANESTHESIA
- ◯ OTHER (PLEASE LIST) ______

Medications

Are you currently taking any medications? ◯ YES ◯ NO

If yes, please give reasons for taking (or attach list) ______

______

______

______ PHARMACY NAME

SIGNATURE ______ DATE ______