# Benedict M. Rich DDS

**Today's Date: _____ Your Name: _____ Birth date: _____**

**Address: _____**

**City: _____State: _____Zip: _____**

**Phone: Home _____ Mobile_____Email _____**

**Referred By: _____**

**Person Responsible for Account: _____**

**Physician: _____City: _____Phone: _____**

**Are you now under a physician's care? _____No ◯ Yes ◯**

**If yes, for what? _____**

**Are you taking any medications? _____No ◯ Yes ◯**

**If yes, please list:_____**

**Are you allergic to any drugs or medications? _____No ◯ Yes ◯**

**If yes, please list:_____**

**Do you have a heart murmur or valve prolapse? _____No ◯ Yes ◯**

**Do you have heart disease? _____No ◯ Yes ◯**

**Do you have an artificial joint or heart valve? _____No ◯ Yes ◯**

**Do you bruise easily or have excessive bleeding? _____No ◯ Yes ◯**

**Do you have diabetes? _____No ◯ Yes ◯**

**Do you have liver disease or hepatitis? _____No ◯ Yes ◯**

**Do you have lung disease or asthma? _____No ◯ Yes ◯**

**Do you have high blood pressure? _____No ◯ Yes ◯**

**Do you have kidney disease? _____No ◯ Yes ◯**

**Do you have a seizure disorder? _____No ◯ Yes ◯**

**Do you have any medical condition not listed? _____No ◯ Yes ◯**

**If yes, please list:_____**

**_____**