Benedict Rich DDS

Name _____ Birth Date _____ Today's Date _____

Address _____

City _____ State _____ Zip _____ Email _____

Phone: Home _____ Work _____ Mobile _____

Person responsible for account _____ Referred by_____

Physician _____ City _____ Phone_____

Are you now under a physician's care? _____ No ☐ Yes ☐

Yes, for what? _____

Are you taking any medications? _____ No ☐ Yes ☐

Yes, please list _____

Are you allergic to any drugs or medications? _____ No ☐ Yes ☐

Yes, please list _____

Do you have a heart murmur or history of endocarditis? _____ No ☐ Yes ☐

Do you have heart disease? _____ No ☐ Yes ☐

Do you have an artificial joint or heart valve?_____ No ☐ Yes ☐

Are you on blood thinners 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 kidney disease? _____ No ☐ Yes ☐

Do you have high blood pressure? _____ No ☐ Yes ☐

Do you have a seizure disorder? _____ No ☐ Yes ☐

Do you have any medical condition not listed? _____ No ☐ Yes ☐

If Yes, please list _____

_____ Thank you

_____

_____

_____

_____