Dr. Lindsey Clark-Fass, DDS, PC

UPDATE

PATIENT INFORMATION

Please print:

Name:_____ SS#:_____ Birthday:_____

Home #:_____ Cell #:_____ Work#:_____

Address:_____City/State/Zip:_____

E-mail address:_____

Check the appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Patient or parent's employer:_____ Address:_____

Spouse or parent's name:_____ Employer:_____

****** IF YOU HAVE HAD ANY DENTAL INSURANCE/EMPLOYMENT CHANGES PLEASE LET US KNOW******

IN THE EVENT OF EMERGENCY

Whom should we contact? _____ Relationship to patient: _____

Home#:_____ Cell#:_____ Work#:_____

Who is your medical doctor? _____ Doctor's phone#:_____

MEDICAL HISTORY

Are you taking any of the following? ☐Blood thinners (including aspirin/fish oil) ☐Insulin ☐Muscle relaxers ☐Osteoporosis meds (bisphosphonates) ☐Pain killers ☐Nerve pills ☐Stimulants ☐Tranquilizers

*****PLEASE LIST *ALL* MEDICATIONS:_____**

Do you have any of the following medical conditions, diseases or procedures?

☐Alcohol/drug abuse	☐Epilepsy/seizures	☐Leukemia
☐Anemia	☐Frequent/severe headaches	☐Liver problems
☐Arthritis/Rheumatism	☐Fainting	☐Mitral valve prolapse
☐Artificial joints/bones	☐Glaucoma	☐Nervousness/anxiety
☐Artificial valves	☐Heart attack	☐Pacemaker
☐Asthma	☐Heart burn/acid reflux	☐Psychiatric problems
☐Back/neck problems	☐Heart disease	☐Rheumatic fever
☐Cancer/tumors	☐Heart murmur	☐Scarlet fever
☐Chemo/radiation therapy	☐Heart surgery	☐Shingles
☐Chest pains/angina	☐Hepatitis A/B/C/D	☐Sinus problems
☐Congenital heart defect	☐High/low blood pressure	☐Stomach problems/ulcers
☐Cosmetic surgery	☐High cholesterol	☐Stroke
☐Diabetes/hypoglycemia	☐HIV/AIDS/ARC	☐Thyroid problems
☐Difficulty breathing	☐Jaw/TMJ problems	☐Tuberculosis
☐Emphysema/respiratory problems	☐Kidney problems	☐Venereal disease

*****Do you require pre-medication before dental procedures? ☐ Yes ☐ No ☐ I don't know**

Please list any other surgeries or medical conditions you have had in the past or currently have now:

_____

Are you allergic to any of the following: ☐Aspirin ☐Dental anesthetics ☐Latex ☐Penicillin/amoxicillin ☐Sulfas ☐Tetracycline ☐Dental anesthetics ☐Foods:_____ ☐Other:_____

Do you use tobacco products? ☐No ☐Yes What type?_____ How much?_____ How long?_____

Please rate your general health from 1-10 (10 being the best)

Have you ever taken the drug Phen-fen and/or Redux?☐Yes ☐No Do you wear contact lenses?☐Yes ☐No

For women: Are you taking birth control? ☐Yes ☐No How many children have you had?____

Are you or could you be pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No

Patient/Guardian signature: _____ Date:_____