trumbull
DENTAL ARTS
FAMILY AND COSMETIC DENTISTRY

Date: _____

PATIENT INFORMATION

Name_____Email:_____
Home Phone _____Cell Phone _____Work Phone_____
Address_____
City _____State _____ Zip Code _____
SS# _____Date of Birth _____ ☐ Male ☐ Female
Employer_____

MEDICAL INFORMATION

Are you under the care of a physician? ☐ YES ☐ NO Physician Name: _____
Has there been any changes in your health within the past year? ☐ YES ☐ NO
If yes, please explain: _____
Have you had any serious illnesses, operations or been hospitalized in the past 2 years? ☐ YES ☐ NO
If yes, please explain: _____

Please CHECK to indicate if you have or have had any of the following conditions or diseases. Your answers are for our records only and will be considered confidential. Please note that during your visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

☐ Artificial Heart Valve	☐ High Cholesterol	☐ Seizures
☐ Heart Murmur	☐ Abnormal Bleeding/Blood Disorder	☐ AIDS/HIV
☐ Heart Surgery	☐ Autoimmune Disease	☐ Kidney Disease
☐ Heart Disease	☐ Tuberculosis	☐ Epilepsy
☐ Heart Attack	☐ Stroke	☐ Mental Disorder
☐ Pacemaker	☐ Cancer	☐ Thyroid Problem
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Gastrointestinal Issues
☐ Headaches/Migraines	☐ Diabetes	☐ Seasonal Allergies/Hay Fever
☐ Sinus Problems	☐ Hepatitis	☐ Sexually Transmitted Disease

Any other diseases, conditions, or problems not listed above? Please explain:
_____

WOMEN

Are you pregnant? How far along: _____ Nursing? _____ Are you taking birth control pills? _____

Have you had allergic reactions to: ☐ Local anesthetic ☐ Penicillin or other Antibiotics ☐ Aspirin ☐ Other

LIST MEDICATIONS

_____ _____
_____ _____
_____ _____
_____ _____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction, I will not hold any dentist, or any other member of her staff, responsible for errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____