



## WELCOME.....

(PLEASE PRINT)

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please read and complete each of the following sections. If the Patient is a minor under the age of 18 years, a Parent/Guardian **MUST** complete and sign the final section. The Guarantor **MUST** be 18 years or older. The better we communicate, the better we can care for you. And **thank you...** for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at anytime, please ask us. We will be happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the COG and the ADA.

.....The Doctors and Staff of Roberts Family Dental, P.C.

### Section A – Patient Information

(Please Print)

Today's Date: \_\_\_\_\_

Name (First/MI/Last) \_\_\_\_\_

Sex:  Male  Female Title:  Mr.  Mrs.  Ms.  Dr

SSN#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_

Apt#: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Telephone No: Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

E/Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

If you are a **Full Time** college student, list the School's Name:  
 (City/State): \_\_\_\_\_

### Section B – Patient Allergy ALERT

(Please check)

Have you ever had an allergic reaction to? **No Yes**

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| 1. LATEX                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Aspirin                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Codeine or Percocet or Percodan | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Darvon                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Demerol                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Erythromycin                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ibuprofen/Motrin                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Local Anesthetic                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Nitrous Oxide                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Penicillin                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Tetracycline                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Other _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Other _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Other _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Other _____                    | <input type="checkbox"/> | <input type="checkbox"/> |

### Section C – Patient Medical History

(Please check)

Are you or Do you or Have you ever had... **No Yes**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Taking <b>ANTICOAGULANTS?</b>                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Taking <b>ASPIRIN?</b>                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Taking <b>COUMADIN</b>                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Taking <b>ST JOHN'S WART?</b>                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. <b>Hospitalized for a recent illness or surgery?</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Smoke or use tobacco?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Drink coffee, tea or cola?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Currently under the care of a physician?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Nervousness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Aids/HIV+/ STD                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Allergies/Hay Fever                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Anemia  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Artificial Bones/Joints                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Asthma/Difficulty Breathing                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Back or Neck Problems                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Blood Pressure – High/Low                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Blood Transfusion                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Cancer/Chemotherapy                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Diabetes  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Dizziness or Fainting                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Drug/Alcohol Abuse                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Emphysema   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Epilepsy/Seizures                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Headaches   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Heart Attack  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Heart - Bacterial Endocarditis                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Heart - Heart Valve Replacement                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Heart - Pace Maker                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Hemophilia  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Hepatitis A or B                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Kidney or Liver or Ulcer Problems                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Rheumatic or Scarlet Fever                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Sickle Cell Disease                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Sinus Trouble                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Shingles or Tuberculosis (TB)                       | <input type="checkbox"/> | <input type="checkbox"/> |

Please list any other medical conditions/allergies that aren't listed? \_\_\_\_\_

