Dr. Eric McDonough DMD

MEADOW DENTAL CENTER

NAME_____ DATE OF BIRTH_____ MALE FEMALE

STREET_____ CITY_____ STATE_____ ZIP_____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ WORK ( ) _____

Text message reminders? YES NO **E-mail reminders? YES NO** _____

SOCIAL SECURITY #_____EMPLOYER/SCHOOL_____

DENTAL INSURANCE CO._____ (please provide card for photocopy)

If different from above:

INSURED'S NAME_____DATE OF BIRTH_____MALE FEMALE

STREET_____ CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY #_____ EMPLOYER/SCHOOL_____

EMERGENCY CONTACT: NAME_____PHONE ( ) _____

Are you under the care of a physician? (Dr._____ for: _____) YES NO

Are you taking any medication? Please list: _____

_____

Are you allergic to anything? (Penicillin, Codeine, Acrylic, Metal, Latex, other) _____ YES NO

Have you ever been hospitalized? Please explain: _____ YES NO

Have you ever had a serious injury to your head or neck? _____ YES NO

WOMEN (**Circle all that apply**) Pregnant - Possibly pregnant - Nursing - Taking oral contraceptives

Are you allergic to any anesthetics? _____ YES NO

Do you wish to talk to the dentist privately about any problems? YES NO

Do you have or have you ever had any of the following? **Please Circle Yes or No next to each item**

Heart trouble	Yes No	bruise easily	Yes No	emphysema	Yes No	kidney problems	Yes No	fever blisters	Yes No
Heart murmurr	Yes No	chemotherapy	Yes No	tuberculosis	Yes No	renal dialysis	Yes No	herpes	Yes No
Irregular heartbeat	Yes No	excessive bleeding	Yes No	cancer	Yes No	thyroid disease	Yes No	stroke	Yes No
Chest pain	Yes No	radiation treatment	Yes No	sickle cell	Yes No	parathyroid disease	Yes No	convulsions	Yes No
Heart attack/failure	Yes No	hemophilia	Yes No	anemia	Yes No	arthritis/gout	Yes No	hepatitis	Yes No
Congenital heart disorder	Yes No	blood transfusion	Yes No	stomach disease	Yes No	rheumatism	Yes No	cold sores	Yes No
Mitral valve prolapse	Yes No	leukemia	Yes No	ulcers	Yes No	psychiatric care	Yes No	glaucoma	Yes No
Scarlet fever	Yes No	swelling limbs	Yes No	weight loss	Yes No	cortisone medicine	Yes No	asthma	Yes No
Rheumatic fever	Yes No	lung disease	Yes No	diarrhea	Yes No	artificial joint	Yes No	nervousness	Yes No
Artificial heart valve	Yes No	breathing problems	Yes No	diabetes	Yes No	venereal disease	Yes No	jaw pain	Yes No
Pacemaker	Yes No	shortness of breath	Yes No	excessive thirst	Yes No	Alzheimer's disease	Yes No	AIDS	Yes No
Heart surgery	Yes No	frequent cough	Yes No	hypoglycemia	Yes No	HIV positive	Yes No	allergies	Yes No
High blood pressure	Yes No	hay fever	Yes No	liver disease	Yes No	genital herpes	Yes No	hives/rash	Yes No
Low blood pressure	Yes No	sinus trouble	Yes No	epilepsy/seizures	Yes No	drug addiction	Yes No	osteoporosis	Yes No
Blood disease	Yes No	tumors/growths	Yes No	yellow jaundice	Yes No	fainting/dizziness	Yes No	Autism	Yes No

Do you snore? YES NO

Do you feel rested in the morning? Please explain: _____ YES NO

Do you use any tobacco product ? _____ YES NO

Do you have a specific dental problem? Please explain: _____ YES NO

Do you like your smile? Please explain: _____ YES NO

Do you have: Sensitive Teeth Bleeding Gums Sore Jaw

Have you had a bad dental experience? Please explain: _____ YES NO

Who can we thank for referring you? _____

I have read everything on this form and have answered correctly to the best of my knowledge.

SIGNATURE_____ **DATE**_____