Mark St. George, DDS
Family & Cosmetic Dentistry
10128 Cedar Lane
Kensington, MD 20895

Name_____ Street_____
City_____ State_____ Zip_____ Home Phone_____Work Phone_____
Date of Birth___/___/___ M/F Height_____ Weight_____ Occupation_____ Cell Phone_____
SS#_____ Marital Status S M D W Name of Spouse_____
Email address:_____
Closest Relative and contact info:_____

Insurance Information Subscriber Name_____ Subscriber SSN_____DOB_____
Employer_____ Group #_____
Ins.Co. Name_____ Ins. Co. Street_____Ins Co. City_____
State_____Zip_____ Who may we thank for referring you?_____

For the following questions, check YES or NO, Whichever applies. Yours answers are confidential and for our records only.

YES **NO**

____ ____ 1. Are you in good health?
____ ____ 2. Has there been any change in your general health within the past year?
____ ____ 3. My last physical exam was on _____; My last dental exam was on_____
____ ____ 4. Are you under the care of a Physician?
If so, what is the condition being treated?_____
Physician's name_____ Phone_____
____ ____ 5. Have you had a serious illness, been hospitalized or had an operation in the past 5 years?
____ ____ 6. Do you have any of the following diseases or problems:
____ ____ a. Damaged Heart valves or artificial heart valves, including heart murmur or Mitral Valve Prolapse?
____ ____ b. Cardiac pacemaker, Congenital heart lesions.
____ ____ c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary
____ ____ occlusion, high blood pressure, arteriosclerosis, stroke)
____ ____ d. Allergy? If so, what are you allergic to? _____
____ ____ e. Sinus trouble?
____ ____ f. Asthma or hay fever?
____ ____ g. Hives or a skin rash?
____ ____ h. Fainting spells or seizures?
____ ____ i Diabetes?
____ ____ j. Hepatitis, jaundice, or liver disease?
____ ____ k. Joint replacement surgery?
____ ____ l. Inflammatory rheumatism (painful swollen joints)?
____ ____ m. Stomach ulcers – GERD (gastro esophageal reflux disease)?
____ ____ n. Kidney trouble?
____ ____ o. Tuberculosis?
____ ____ p. Epilepsy?
____ ____ q. Psychiatric problems?
____ ____ r. Cancer?
____ ____ s. HIV, AIDS, Venereal disease, or Herpes?
____ ____ t. Other:_____
____ ____ 7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
____ ____ a. Have you required a blood transfusion?

____ ____ 8. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?
____ ____ 9. Are you taking any drug or medication? If so, what?_____
____ ____ 10. Are you taking any of the following:
____ ____ a. Antibiotics or sulfa drugs?
____ ____ b. Anticoagulants (blood thinners)?
____ ____ c. Medicine for high blood pressure?

(other side→)

____ ____ d. Cortisone (steroids)?
____ ____ e. Tranquilizers?
____ ____ f. Antihistamines?
____ ____ g. Aspirin?
____ ____ h. Insulin?
____ ____ i Digitalis or drugs for heart trouble?
____ ____ j. Nitroglycerin?
____ ____ k. Oral contraceptives or other hormonal therapy?
____ ____ l. Other:_____

11. Are you allergic or have you reacted adversely to:
____ ____ a. Local anesthetics?
____ ____ b. Penicillin or other antibiotics?
____ ____ c. Sulfa drugs?
____ ____ d. Barbiturates, sedatives, or sleeping pills?
____ ____ e. Aspirin?
____ ____ f. Iodine?
____ ____ g. Codeine or other narcotics?
____ ____ h. Other:_____

12.What is your chief dental complaint?_____

____ ____ 13.Have you had any serious trouble associated with any previous dental treatment?

____ ____ 14. Do you have any disease, condition, or problem not listed above that you think I should know about?
If so, explain:_____

____ ____ 15. Are you wearing removable dental appliances?
____ ____ a. Night guard?
____ ____ b. Retainers?
____ ____ c. Partial dentures?

____ ____ 16. Have you ever been told by a dentist that you have any of the following:
____ ____ a. Gum disease (gingivitis/periodontitis)?
____ ____ b. TMJ dysfunction?

WOMEN

____ ____ 17. Are you pregnant?
____ ____ 18. Do you have any problems associated with your menstrual period?
____ ____ 19. Are you nursing?

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

Signature of Patient:_____ Date: _____
(If a minor, parent or guardian must sign)

Signature of Dentist:_____ Date:_____