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 Closest Relative Phone Email:

**Insurance Information** Subscriber Name Subscriber SSN DOB

Employer Group # Ins.Co. Name Ins. Co.

Street Ins Co. City State Zip Who referred 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  |
|  |   | 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:

1. Damaged Heart valves or artificial heart valves, including heart murmur or Mitral Valve Prolapse?
2. Congenital heart lesions.
3. Cardiovascular disease (heart trouble, heart attack, coronary

insufficiency, coronary

occlusion, high blood pressure, arteriosclerosis, stroke) 1.Do you have pain in you chest upon exertion?

1. Are you ever short of breath after mild exercise?
2. Do you have a cardiac pacemaker?
3. Allergy? If so, what are you allergic to?
4. Sinus trouble?
5. Asthma or hay fever?
6. Hives or a skin rash?
7. Fainting spells or seizures?

i Diabetes?

1. Do you have to urinate more than six times a day?
2. Are you thirsty much of the time?
3. Does your mouth frequently become dry?
4. Hepatitis, jaundice, or liver disease?
5. Arthritis?
6. Inflammatory rheumatism (painful swollen joints)?
7. Stomach ulcers?
8. Kidney trouble?
9. Tuberculosis?
10. Do you have a persistent cough or cough up blood?
11. Low blood pressure?
12. Venereal Disease?
13. Epilepsy?
14. Psychiatric problems?
15. Cancer?
16. AIDS or other immunosuppressive disorders?
17. Other:

 7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?

a. Have you required a blood transfusion?

 8. Do you have any blood disorders such as anemia?

 9. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?

 10. Are you taking any drug or medication? If so, what?

Other:

1. Are you taking any of the following:
	1. Antibiotics or sulfa drugs?
	2. Anticoagulants (blood thinners)?
	3. Medicine for high blood pressure?
	4. Cortisone (steroids)?
	5. Tranquilizers?
	6. Antihistamines?
	7. Aspirin?
	8. Insulin, tolbutamide (Orinase), or similar drug? i Digitalis or drugs for heart trouble?
2. Nitroglycerin?
3. Oral contraceptives or other hormonal therapy? l.
4. Are you allergic or have you reacted adversely to:
	1. Local anesthetics?
	2. Penicillin or other antibiotics?
	3. Sulfa drugs?
	4. Barbiturates, sedatives, or sleeping pills?
	5. Aspirin?
	6. Iodine?
	7. Codeine or other narcotics? h.

Other: 13.What is your chief dental

complaint:

 14.Have you had any serious trouble associated with any previous dental

treatment?

 15. Do you have any disease, condition, or problem not listed above that you think I should know about?

If so,

explain:

 16. Are you employed in any situation with exposes you regularly to x-rays or other ionizing radiation?

 17. Are you wearing removable dental appliances?

WOMEN

 18. Are you pregnant?

 19. Do you have any problems associated with your menstrual period?

 20. Are you nursing?

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquires set forth above have been answered 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: