Welcome to Galena Dental

PERSONAL INFORMATION

Name ____________________ Date of Birth ____________

Address ____________________

Home Phone ____________ Social Security Number ____________

Person to Contact in Case of Emergency ____________________

Emergency Phone Number ____________________

Employer ____________ Phone ____________

Reason for Your Appointment ____________________

Referred by ____________________

MEDICAL INFORMATION

Have you ever suffered from or been diagnosed with any of the following:

YES	NO	Condition
☐	☐	AIDs or HIV Infection
☐	☐	Allergies to Penicillin, Aspirin, Codeine, Sulfa Drugs, Others
☐	☐	Asthma
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Kidney Problems
☐	☐	Hepatitis
☐	☐	Heart Murmur
☐	☐	Heart Disease of Any Kind
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Problems with Mental Health

YES	NO	Condition
☐	☐	Sexually Transmitted Disease
☐	☐	Swollen Glands
☐	☐	Tuberculosis
☐	☐	Thyroid Problems
☐	☐	Respiratory Problems
☐	☐	Are Your Pregnant
☐	☐	Are You Nursing
☐	☐	Anemia
☐	☐	Bleeding Disorders
☐	☐	Fear of Dentists in General
☐	☐	Drug Dependency
☐	☐	Alcohol Dependency
☐	☐	Abnormal Bleeding
☐	☐	Fainting Dizziness
☐	☐	Sinus Problems
☐	☐	TMJ Problems

Please include any information not mentioned above: ____________________

Are you currently taking any medication? ____________________

Name of your physician ____________________

I certify that I have read and understand 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 my dentist or any 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 ____________