PATIENT NAME: BIRTHDATE:

MARITAL STATUS: FULL NAME OF SPOUSE:

IF PATIENT IS A CHILD, LIST PARENT NAME:

RESIDENCE ADDRESS:

CITY: STATE: ZIP:

HOME PHONE: BUSINESS PHONE: CELL PHONE:

EMPLOYED BY: OCCUPATION:

SPOUSE EMPLOYED BY: OCCUPATION:

SOCIAL SECURITY NUMBER: E-MAIL:

REFERRED TO US BY:

PREVIOUS DENTIST:

DATE OF LAST TREATMENT: DATE OF LAST X-RAYS:

PHYSICIAN: DATE OF LAST PHYSICAL EXAM:

PHYSICIAN ADDRESS AND PHONE:

EMERGENCY CONTACT AND PHONE

HAVE YOU EVER HAD OR BEEN TREATED FOR:

❑ Yes	❑ No	*Heart Disease*	❑ Yes	❑ No	*Arthritis*	❑ Yes	❑ No	*OrthopedicJoint Replacement*
❑ Yes	❑ No	*Rheumatic Fever*	❑ Yes	❑ No	*Heart Murmur,*	❑ Yes	❑ No	*Excessive Bleeding*
❑ Yes	❑ No	*Tuberculosis*			*Mitral Valve Prolapse*	❑ Yes	❑ No	*Hay Fever*
❑ Yes	❑ No	*Pacemaker*	❑ Yes	❑ No	*Kidney Disorders, Dialysis*	❑ Yes	❑ No	*Asthma, Emphysema*
❑ Yes	❑ No	*Congenital Heart Problems*	❑ Yes	❑ No	*Abnormal Blood Pressure*	❑ Yes	❑ No	*Sinus Trouble*
❑ Yes	❑ No	*Epilepsy, Seizure*	❑ Yes	❑ No	*Radiation Therapy*	❑ Yes	❑ No	*Sexually Transmitted Disease*
❑ Yes	❑ No	*Chest Pains, Angina*	❑ Yes	❑ No	*Cancer*	❑ Yes	❑ No	*Ulcers*
❑ Yes	❑ No	*Aids, HIV Positive*	❑ Yes	❑ No	*Glaucoma*	❑ Yes	❑ No	*Anemia*
❑ Yes	❑ No	*Growth or Tumor*	❑ Yes	❑ No	*Nervous Disorders*	❑ Yes	❑ No	*Rheumatic Heart Disease*
❑ Yes	❑ No	*Heart Attack, Heart Surgery*	❑ Yes	❑ No	*Diabetes*	❑ Yes	❑ No	*Banana or Latex Allergy*
❑ Yes	❑ No	*Stroke*	❑ Yes	❑ No	*Hepatitis, Juandice*	❑ Yes	❑ No	*Acrylic Allergy*

WOMEN: ARE YOU PREGNANT? WHAT MONTH? ARE YOU TAKING BCP?

DO YOU PRE-MEDICATE BEFORE PROCEDURES? ❑ Yes ❑ No DO YOU SMOKE? ❑ Yes ❑ No

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

HAVE YOU HAD ALLERGIC OR UNUSUAL REACTIONS TO:

❑ PENICILLIN ❑ ASPIRIN ❑ ANESTHETICS (E.G. NOVOCAINE) ❑ NITROUS OXIDE ❑ CODEINE

ANY OTHER ALLERGIES:

DO YOU HAVE DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

PLEASE LIST ANY HISTORY OF DISEASE OR ILLNESS IN YOUR FAMILY (E.G. DIABETES, HIGH BLOOD PRESSURE, ETC.)

HAVE YOU EXPERIENCED ANY UNFAVORABLE REACTION FROM ANY PREVIOUS DENTAL TREATMENT? (EXPLAIN)

WHAT IS YOUR REASON FOR THIS VISIT:

PATIENT SIGNATURE: _____ DATE: _____

RONALD C. RUSSO, D.M.D. *7500 E. McDONALD DRIVE • SUITE 101-B • SCOTTSDALE, AZ 85250*
(480) 998-3355 • FAX (480) 948-5153