Kirtley & Stuckwisch, LLC

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Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ ___ _____-____
City State Zip Code

Employer Name:

_____

_____

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Medical Infomation

Have there been any changes to your medical history since your last dental visit? * ◯ Yes ◯ No

If yes, please list below.

_____

_____

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ AcetaminophenAllergy
- ☐ Amoxicillin Allergy
- ☐ Ampicillin Allergy
- ☐ Anemia
- ☐ Anesthetic Allergy
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Augmentin Allergy
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Ceclor Allergy
- ☐ Cerebral Palsy
- ☐ Chloral Hydrate
- ☐ Codeine Allergy
- ☐ Crohn's Disease
- ☐ Darvon Allergy
- ☐ Demerol Allergy
- ☐ Diabetes
- ☐ Doxycycline Allergy
- ☐ Dye Allergy
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Fibromyalgia
- ☐ Food Allergy
- ☐ Glaucoma
- ☐ Headaches / Injuries
- ☐ Heart Issues/Surgery
- ☐ Heart Murmur
- ☐ Hepatitis A,B, or C
- ☐ High Blood Pressure
- ☐ Hip Replacement
- ☐ HIV+/AIDS
- ☐ Ibuprofen Allergy
- ☐ Jaundice
- ☐ Keflex Allergy
- ☐ Kidney Disease
- ☐ Knee Replacement
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolap
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nervous Disorders
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Other
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Premedicate
- ☐ Radiation / Chemo
- ☐ Reglan Allergy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Tetracycline Allergy
- ☐ Tuberculosis
- ☐ Tumors / Growths
- ☐ Ulcers
- ☐ Z Pack Allergy

☐ FEMALE: Taking birth control pills ☐ A smoker or smoked previously ☐ Do you use alcohol ☐ Do you use cocaine or other drugs

☐ LATEX allergy or sensitivity ☐ Pregnant/Nursing

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

_____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Response Date: _____