



David Canale Family Dentistry

*Dental Care
You Can Smile About*

Welcome To Our Office - Tell Us About Yourself

Name _____		Male _____ Female _____	
Address _____		Email _____	
City _____		State _____	Zip _____
Home Phone _____		Social Security # _____	Birthdate _____
Cell Phone _____		☐ Married	☐ Single ☐ Divorced ☐ Widowed
Employed By _____			
City _____		State _____	Zip _____ Referred By _____
Dental Insurance Carrier _____		Secondary Ins. _____	
Person Financially Responsible For Account _____			
Address _____		City _____	State _____ Zip _____
Cell Phone _____		Social Security # _____	Birthdate _____
Employed By _____		Address _____	
Primary Reason For This Visit _____			

Please answer each question. Circle YES or NO

1. Are you under medical treatment now? Yes No If yes, please explain _____	4. Are you taking any drugs or medications? Yes No If yes, please list _____
2. Have you had any operations? Yes No If yes, please list _____	5. When cut, does your bleeding stop within a normal period of time? Yes No
Are you allergic to penicillin, latex or any other drugs or medications? Yes No If yes, please list _____	6. Do you have any other health problems which you wish to discuss with the Doctor? Yes No
	7. Do you require antibiotics before dental treatment? Yes No
	8. Women: are you pregnant? Yes No

Do you have or have you had any of the following?

Heart Ailment	Yes No	Nervous Disorder	Yes No	Kidney Disease	Yes No
High Blood Pressure	Yes No	Epilepsy	Yes No	Ulcers	Yes No
Cardiac Pacemaker	Yes No	History of Fainting	Yes No	Respiratory Disease	Yes No
Rheumatic Fever	Yes No	Tuberculosis	Yes No	Sinus Trouble	Yes No
Heart Murmur	Yes No	Hepatitis	Yes No	Serious Head Injury	Yes No
Blood Disease or Anemia	Yes No	Tumors or Growths	Yes No		
Diabetes	Yes No	Liver Disease	Yes No	Other _____	Yes No

Is your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I confirm that the above information is true to the best of my knowledge and I consent to whatever dental procedures, including X-rays and local anesthetics that are deemed necessary for diagnosis and treatment.

Signature _____ Date _____