



# 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<br>If yes, please explain _____                               | 4. Are you taking any drugs or medications? Yes No<br>If yes, please list _____            |
| 2. Have you had any operations? Yes No<br>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<br>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 | STD                 | 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 \_\_\_\_\_