Erik J. Tallbacka, DMD • Stuart, Fl

PATIENT

Name _____ Date _____

[ ] Single [ ] Married [ ] Other [ ] Child Birth Date ___/___/___ S.S.# _____

HomeAddress _____ City _____ State ___ Zip _____

Home Phone(___)_____ Work(___)_____ Cell(___)_____

E-mail Address _____ Occupation _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above. Name _____ Birth Date ___/___/___

Billing Address _____ City _____ State ___ Zip _____

Home Phone(___)_____ Work(___)_____ Cell(___)_____

E-mail Address _____ Occupation _____

Insurance [ ] yes [ ] no Carrier: _____ Subscriber _____

Birth Date ___/___/___ ID# _____ Group# _____

Who referred you to our office? _____

MEDICAL HISTORY INFORMATION

Have you been under the care of a physician in the last 2 years? _____ Name of physician _____

Have you had any major surgery? _____ What kind ? _____

Do you have an allergy to any medications? _____ List _____

Do you smoke or use tobacco products? _____ How often? _____

Please list all medications taken in the last year (incl. Birth Control) _____

_____

Have you had or do you have:

	Yes	No		Yes	No
Allergies	()	()	Prolonged bleeding	()	()
Anemia	()	()	Mitral Valve Prolapse	()	()
Arthritis	()	()	Drug Dependency	()	()
Artificial joints	()	()	Epilepsy	()	()
Cancer	()	()	Heart Disease	()	()
Chemotherapy	()	()	Heart murmur	()	()
Congenital Heart Lesion	()	()	Hepatitis	()	()
Liver Disease	()	()	Rheumatic Fever	()	()
Organ Transplant	()	()	Stroke	()	()
Pace Maker	()	()	Tuberculosis	()	()
HIV/AIDS	()	()			

Any diseases, conditions, or problems not mentioned above?

DENTAL HEALTH HISTORY

Primary purpose of your dental appointment? _____

Is there anything that concerns you about your teeth/gums? _____

Do you have a history of decay or gum problems? [ ] yes [ ] no. Do your gums bleed when brushing /flossing? [ ] yes [ ] no

Have you been pleased with previous dental experiences [ ] yes [ ] no

If you could change one thing about your teeth, what would it be? _____

Signature _____ (parent or guardian if child)