Softouch Dental Care - *Changing Lives One Smile at a Time*

Name: _____ _____ _____
(Last) First MI Social Security # Date of Birth

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other

Phone: _____ _____ _____
Home Work Cell

Address: _____
City State Zip Code

Employer: _____

Address: _____ Occupation: _____

City,St,Zip _____

Email: _____ May we contact you by email? ❑ Yes ❑ No

HEALTH INFORMATION

Date and Reason of Last Dental Visit: _____

Have you ever had any of the following? Please check **ALL** that apply:

- ❑ ADD
- ❑ AIDS
- ❑ Allergy – Aspirin
- ❑ Allergy – Codeine
- ❑ Allergy – Erythromycin
- ❑ Allergy - Latex
- ❑ Allergy – Nickel
- ❑ Allergy – Penicillin
- ❑ Allergy – Sulfa
- ❑ Allergy – Tetracycline
- ❑ Allergy – OTHER_____
- ❑ Anemia
- ❑ Arthritis
- ❑ Aspirin Therapy
- ❑ Asthma
- ❑ Avoid Epi / Use Carbo
- ❑ Blood Disease / Thinner
- ❑ Cancer
- ❑ Clenching / Grinding
- ❑ Coumadin / Blood Thinners
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Highly Anxious
- ❑ HIV Positive
- ❑ Hormone Replacement
- ❑ HX Dental Trauma
- ❑ HX Perio Surgery
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mental Disorders
- ❑ Needle Phobia
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Currently Pregnant
  Due Date:_____
- ❑ Premed Abio/PrevntSBE
- ❑ Premed Valium/Xanax
- ❑ ProstheJoint-premed
- ❑ Radiation Treatment
- ❑ Recent Weight Loss
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Sleep Apnea
- ❑ Smoker
- ❑ Snoring
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Swollen Ankles
- ❑ TMJ
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ OTHER:_____

Do you have any health problems that need further clarification?_____

Please list any medications, including herbal supplements_____

In the event of an Emergency, whom should we contact?_____ Tel:_____

General Health (Please circle): EXCELLENT GOOD FAIR POOR

Name of Physician:_____ Telephone:_____

Are you currently under the care of a physician? ❑ Yes ❑ No

REFERRAL INFORMATION: Whom may we thank for referring you to our Practice?_____

- ❑ Our Website
- ❑ Cosmeticdentistry.com
- ❑ Aboutcosmeticdentistry
- ❑ Current Patient
- ❑ Las Vegas Institute (LVI)
- ❑ 1-800-BEST-DDS
- ❑ Cheesecake Factory
- ❑ Yellow Pages
- ❑ Radio: WTOP
- ❑ Radio: WMAL
- ❑ Radio: WASH-FM
- ❑ Television/Cable
- ❑ NBC News Channel 4
- ❑ DC Magazine
- ❑ Elan Magazine-Fairfax
- ❑ Elan Magazine-Loudoun
- ❑ New Beauty Magazine
- ❑ Washingtonian Magazine
- ❑ DentaLife Magazine
- ❑ Channel 8 - A New Me

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Print Name:_____ _____
Signature of Guest, Parent or Guardian

Date: _____

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