Carino Family Dentistry

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Gainesville, VA 20155
(703) 754-6622 (Ph)

In order to serve you properly, we need the following information.
All information is strictly confidential (**Please print clearly)** **Today's Date**: _____/_____/_____

GENERAL

Patient's Name: _____ Preferred Name: _____
First Last M.I.

Gender _____ Birth Date: _____/_____/_____ Soc. Sec. _____-_____-_____ Marital Status_____

Address: _____ City: _____ State: _____ Zip_____
Street Apt #

Home Phone: (_____) _____Work: Number: (_____) _____ Cell Number (_____) _____

Email address: _____ Pharmacy Name/Location: _____

HEALTH HISTORY

Chief Complaint/Reason for Visit: _____ Date of last dental visit? _____

DO YOU HAVE OR USE ANY OF THE FOLLOWING? - (Please check all that apply)

- ❒ AIDS/ HIV
- ❒ Allergies _____ _____
- ❒ Codeine Allergy
- ❒ Latex Allergy
- ❒ Penicillin Allergy
- ❒ Anemia
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Blood Disease
- ❒ Cancer
- ❒ Diabetes
- ❒ Dizziness
- ❒ Epilepsy
- ❒ Excessive Bleeding
- ❒ Fainting
- ❒ Glaucoma
- ❒ Growths
- ❒ Hay Fever
- ❒ Head Injuries
- ❒ Heart Disease
- ❒ Heart Murmur
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ Jaundice
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Mental Disorders
- ❒ Nervous Disorders
- ❒ Pacemaker
- ❒ Pregnant/Nursing: Due Date _____
- ❒ Radiation Treatment
- ❒ Respiratory Problems
- ❒ Rheumatic Fever
- ❒ Rheumatism
- ❒ Sinus Problems
- ❒ Stomach Problems
- ❒ Stroke
- ❒ Tuberculosis
- ❒ Tumors
- ❒ Ulcers

Please list all medications that you are currently taking: _____

_____

YES	NO	
❒	❒	Do you take premedication prior to dental appointments?
❒	❒	Have you ever had any complications following dental treatment?
		Please Explain _____
❒	❒	Have you been admitted to a hospital or needed emergency care in the past two years?
		Please Explain _____
❒	❒	Are you under the care of a physician now?
		Please Explain _____
❒	❒	Name of Physician _____ Phone Number _____
❒	❒	Do you have any further health concerns that need further clarification?
		Please Explain _____

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 doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian **Date**