



*Christopher P. Toomey, DDS, PA*

GENERAL • IMPLANT • COSMETIC DENTISTRY

**Full Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date Of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Sex:** Male Female

**Marital Status:** S M D W

**Home Phone:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Mobile/Pager:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Work:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Dental Insurance:** \_\_\_\_\_ (Please present card at every visit.)

**Name of Policy Holder:** \_\_\_\_\_ **Policy Holder's SS #:** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Policy Holder's DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_ **Patient's SS # (needed for some plans):** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Name of Previous Dentist:** \_\_\_\_\_ **Date of Last Dental Exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**May we request your Dental Records?** Yes No

**Previous Dentist's Phone :** \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**What prompted you to seek Dental Care in our office?** \_\_\_\_\_

**Who may we Thank for Referring You to Us?** \_\_\_\_\_

**Do you currently, or have you in the past, had any of the following:** (Circle Y or N for each.)

Gag Easily	Y N	Mouth Blisters	Y N	Frequent/Severe Headaches	Y N
Bleeding Gums	Y N	Mouth Breathing	Y N	Jaw that pops or clicks	Y N
Gum Treatments	Y N	Smoke	Y N	Grind Teeth	Y N
Burning Tongue	Y N	Chew Tobacco	Y N	Clench Teeth	Y N
Unpleasant Taste	Y N	Pain with Cold	Y N	Tired Jaws	Y N
Bad Breath	Y N	Pain with Hot	Y N	Orthodontic Work	Y N
Mouth Swelling	Y N	Chew on one side	Y N	Dentures	Y N

**Do you have any problems with (please describe where needed):** (Circle Y or N for each.)

Rheumatic Fever?	Y N	Hepatitis?	Y N	Diabetes?	Y N
Heart? _____	Y N	Liver Problems?	Y N	Ulcers?	Y N
*MitroValve Prolapse?	Y N	Tuberculosis?	Y N	Kidney Disease?	Y N
*Murmur?	Y N	Cough?	Y N	Epilepsy?	Y N
Joint Replacement?	Y N	Asthma?	Y N	Anemia?	Y N
Stroke?	Y N	Arthritis?	Y N	Cancer?	Y N
High Blood Pressure?	Y N	Lupus?	Y N	HIV+ Test?	Y N
Low Blood Pressure?	Y N			Psychiatric Care?	Y N
Drug Allergies? Y N : If yes, which? _____		Food Allergies? Y N : If yes, which? _____			

**Please list any Medications that you take (prescription and over-the-counter):**

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**Primary Care Physician:** \_\_\_\_\_ **Date of Last Exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**If necessary, may we contact your physician regarding your health?** Y N

**Is there anything else we should know about your Dental or Medical Health?** Y N

**If yes, please explain:** \_\_\_\_\_  
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**Women:** Are you Pregnant? Y N      Taking Birth Control? Y N      If yes, do you Smoke? Y N

**Signature of Patient or Guardian:** \_\_\_\_\_

**Printed:** \_\_\_\_\_