TOOMEY DENTISTRY

Smiles from the inside out!℠

Name: _____ Date: _____

Address: _____

_____

Email Address: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____/_____/_____ Sex: Male Female Marital Status: S M D W

Emergency Contact: _____ Phone: _____

Dental Insurance: _____

ID #: _____ Group #: _____

Name of Policy Holder: _____

Policy Holder's SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Claims Address: _____

_____

How did you hear about us?

Friend/Family _____ Internet Baltimore Magazine

Do you currently have, or had in the past: (*Circle Yes or No for each*.)

Mouth Blisters	Y	N	Gag Easily	Y	N	Severe Headaches	Y	N
Smoke/Chew	Y	N	Bleeding Gums	Y	N	Jaw that pops/clicks	Y	N
Pain with Hot	Y	N	Gum Treatments	Y	N	Grind Teeth	Y	N
Pain with Cold	Y	N	Unpleasant Taste	Y	N	Tired Jaws	Y	N
Mouth Swelling	Y	N	Bad Breath	Y	N	Orthodontic Work	Y	N

Do you currently have, or had in the past: (*Please describe where needed*.)

Rheumatic Fever	Y	N	Hepatitis	Y	N	Diabetes	Y	N
Heart Murmur	Y	N	Liver Problems	Y	N	Ulcers	Y	N
Mitrovalve Prolapse	Y	N	Tuberculosis	Y	N	Kidney Disease	Y	N
Joint Replacement	Y	N	Asthma	Y	N	Anemia	Y	N
High Blood Pressure	Y	N	Arthritis	Y	N	HIV+	Y	N
Low Blood Pressure	Y	N	Lupus	Y	N	Psychiatric Care	Y	N
Stroke	Y	N	Cancer	Y	N	Epilepsy	Y	N

Drug Allergies: _____

Food/Latex Allergies: _____

Medications you currently take (*prescription AND over-the-counter*):

_____ _____ _____ _____

_____ _____ _____ _____

Primary Care Physician: _____ Phone: _____

Women: Are you pregnant? Y N Date of Last Menstrual Cycle: _____/_____/_____

Signature of Patient or Guardian: _____

Printed Name: _____