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: _____

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 or 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**