Dr. John Feeley

Patient Name:_ Birth Date:________________SS#______________________________
Home Address:________________________________City_________________________State______Zip___________
_
Home #________________Cell#_________________Work #_______________Employer___________________________
Email Address____Referred to us by:__________________________
Spouse's Name:_________________________Spouse's SS#_________________Spouse's Bith Date:___________
Emergency Contact: Name, Relationship and Phone#____

MEDICAL HISTORY

Name and Phone Number of Physician____________________________________Last Complete Physical_____________
Please list any medications you are taking:____

Do you or have you had any of the following diseases, medical conditions or procedures. *PLEASE MARK YES OR NO*

Y/N Heart Atttack/Stroke Y/N Thyroid Problems Y/N Cancer/Tumors Y/N Heart Surg/Pacemaker Y/N Kidney Disease Y/N Chemotherapy Y/N Glaucoma
Y/N Heart Murmur Y/N Emphysema Y/N Diabetes Type 1 or 2 Y/N Hypoglycemia Y/N Blood Disorder
Y/N Respiratory problems Y/N HIV+/Aids/ARC Y/N Biphosphonates Y/N High/Low Blood Pressure
Y/N Arthritis/Rheumatism Y/N Heart Disease Y/N Tuberculosis TB Y/N Stomach Problems/Ulcers
Y/N Sinus Problems Y/N Bleeding Problems Y/N Joint Replacement Y/N Hepatitis
Y/N Frequent Headaches Y/N Scarlet Fever Y/N Alcohol/Drug Abuse Y/N Asthma

BEFORE DENTAL WORK, DO YOU REQUIRE PRE-MEDICATION FOR YOUR HEART/JOINT REPLACEMENT? YES/NO

Please list any other surgeries or medical conditions you have been treated for in the past 10 years not listed above:____
_____

Are you allergic to any of the following? (Please circle)

Penicillin Tetracycline Codeine Aspirin Latex Sulfa Anesthetics

Other______________________________

Do you use tobacco? Y/N How much?______ How long?______ Are you taking birth control pills? Y/N
Are you pregnant? Y/N How far along?______ Are you nursing? Y/N

DENTAL INFORMATION

Are you in pain? Y/N **If yes, when did it begin?_______________**
Please describe symptoms____

Please indicate any of the following problems: __Discomfort, clicking or popping of the jaw __Lost/Broken filling(s) __Swollen or bleeding gums __Clenching/Grinding __Locking jaw __Sensitive teeth or gums __Bad breath __Blisters/Sores in or around the mouth __ Broken/chipped teeth Other:___________________________________

New Patients: Last Dental Exam___________ Last Dental X-rays___________ How often do you brush? ___________

How often do you floss________ Reason for leaving previous practice? ____

Signature____Date____________ _______________