Brian O. Coleman, D.M.D., P.A.

Name_____ Today's Date_____

Address:_____

Home Telephone:_____ Work Telephone:_____

Cellular Telephone:_____ Date of Birth:_____

E-Mail:_____ SS:_____

Responsible Party (if minor):_____

Address:_____

Telephone:_____ DOB:_____ SS#:_____

Emergency Contact:_____ Telephone #_____

Please list any medications you are currently taking:_____

Allergic to:_____

Who may we thank for referring you to our office?_____

Have you ever had any of the following diseases or medical conditions? Please circle.

Artificial bones/joints/valves	Y / N	TB	Y / N
Asthma	Y / N	Abnormal Bleeding	Y / N
Blood Thinners	Y / N	Cancer / Chemotherapy	Y / N
Diabetes	Y / N	Herpes	Y / N
Epilepsy/Seizures	Y / N	High Blood Pressure	Y / N
HIV+/AIDS	Y / N	Surgery	Y / N
Low Blood Pressure	Y / N	Are you Pregnant?	Y / N
Hepatitis	Y / N	Latex Allergy	Y / N
MVP / Heart Disease/Murmur	Y / N	Difficulty Breathing	Y / N
Anemia	Y / N	Pacemaker	Y / N
Thyroid Problems	Y / N	Other Medical Conditions:	_____

Do you require antibiotics before dental treatment?_____ Are you in any discomfort?_____

Have you ever had a serious problem associated with dental treatment?_____

Why have you come to the Dentist today?_____

**I understand that the information I have given is correct, and it is my responsibility to inform the office of any changes. I authorize the Dental Staff to perform the necessary services.

_____ _____

Signature of Patient / Parent / Guardian Date

For Staff Use BP:_____ Pulse:_____