Dr Timothy Rorman, DMD
Dr. Carlo Moreno, DMD

Patient Information

Patient Name: ______________________________ Date: ____________
Last First (Preferred Name)

M / F
☐ ☐ Social Security# ____ - ____ - ____ Date of Birth: ____/____/______ Phone Number ________________ home/cell *( ) Check here to Opt In to Text Messages*

Mailing Address: ______________________ City ____________ State _______ Zip Code __________

Email: ______________________________ *( ) Check here to Opt In to Text Messages*

Health Information

MEDICAL HISTORY

	Yes	No
Are you under a physician's care now? Why? ____________ Who? ____________ Phone ____________	☐	☐
Have ever been hospitalized or had a major operation? Discuss ____________	☐	☐
Have you ever had a serious injury to your head or neck? Discuss ____________	☐	☐
Are you taking any medications, pills, or drugs? What? ____________	☐	☐
Are you on a special diet? Discuss ____________	☐	☐

Are you allergic to any medications or substance? Please check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex/Rubber ☐ Other ____________

Have you ever had any of the following? Please check appropriate boxes.

	Yes	No		Yes	No		Yes	No		Yes	No
Need Premedication	☐	☐	Leukemia	☐	☐	Recent Weight Loss	☐	☐	Cold Sores/Fever Blisters	☐	☐
Heart Murmur	☐	☐	Hemophilia	☐	☐	Frequent Diarrhea	☐	☐	Herpes	☐	☐
Irregular Heart Beat	☐	☐	Glaucoma	☐	☐	Stomach/Intestinal Disease	☐	☐	Ulcers	☐	☐
Angina/Chest Pain	☐	☐	Diabetes	☐	☐	Thyroid Disease	☐	☐	TMJ Problems/Pain in Jaw Joints	☐	☐
Heart Attack/Failure	☐	☐	Swelling of Limbs	☐	☐	Hypoglycemia	☐	☐	Convulsions	☐	☐
Congenital Heart	☐	☐	Lung Disease	☐	☐	Liver Disease	☐	☐	Epilepsy or Seizures	☐	☐
Disorder	☐	☐	Breathing Problems	☐	☐	Hepatitis A (Infectious)	☐	☐	Fainting or Dizziness	☐	☐
Mitral Valve Prolapse	☐	☐	Shortness of Breath	☐	☐	Hepatitis B	☐	☐	Nervousness	☐	☐
Scarlet Fever	☐	☐	Frequent Cough	☐	☐	Hepatitis C	☐	☐	Sinus Trouble	☐	☐
Rheumatic Fever	☐	☐	Hay Fever	☐	☐	Kidney Problems	☐	☐	Hives or Rash	☐	☐
Artificial Heart Valve	☐	☐	Unexplained Fever	☐	☐	Renal Dialysis	☐	☐	Psychiatric Care/Depression	☐	☐
Heart Pacemaker	☐	☐	Asthma	☐	☐	Yellow Jaundice	☐	☐	Allergies-Pollen/Dust	☐	☐
Stroke	☐	☐	Bloody Sputum	☐	☐	Arthritis/Gout	☐	☐	HIV Positive	☐	☐
Heart Surgery	☐	☐	Emphysema	☐	☐	Rheumatism	☐	☐	AIDS	☐	☐
Heart Trouble/ Disease	☐	☐	Tuberculosis	☐	☐	Artificial Joint	☐	☐			
High Blood Pressure	☐	☐	Transfusion	☐	☐	Alzheimer's Disease	☐	☐	Others		
Low Blood Pressure	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Cortisone Medicine	☐	☐	____________		
Blood Disease	☐	☐	Chemotherapy	☐	☐	Alcoholism	☐	☐	____________		
Anemia	☐	☐	Cancer	☐	☐	Drug Addiction	☐	☐	____________		
Excessive Bleeding	☐	☐	Tumors or Growths	☐	☐	Venereal Disease	☐	☐	____________		
Sickle Cell Disease	☐	☐	Excessive Thirst	☐	☐	Genital Herpes	☐	☐			

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X ______________________________ Date: ____________
Patient Signature (Parent or Guardian)

Reviewed By Doctor ____________ Date: ____________ BP: ____________