

Oneal Russell, DDS, LLC
71 Amos Garrett Blvd.
Annapolis, MD 21401
(410) 263- 4300

Section IV: Referral Information

Whom may we thank for referring you to our practice Another patient (friend) Another patient (relative)

Dental office Yellow pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Section V: Dental History

Date of last dental visit: _____

Reason for **current** visit: _____

Have you ever had any complications following dental treatment: Yes No

If yes, please explain: _____

Do you smoke or use other tobacco products: Yes No

If yes, quantity and duration: _____

Section VI: Allergies

- | | | | |
|---|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Penicillin | |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa drugs | |

Other allergies: _____

Section VII: Current Medications

Please list all prescription or over the counter medications: _____

