

Name:		DOB: _	/	/	Sex:	F M	
Address:							
City:	_ State:	Zip:	Phone	e: _(_)		
Email: To receive text messages pleas			lantisturas va	omoil com			
Emergency Contact:		_		_	-	_	
Have you had any recent serious illi							
	•		<u>.</u>				
Are you currently under a physic	cians care?	YES NO If Y	ES, please des	cribe:			
	major crossroads						
PLEASE CIRCLE IF YOU C	<u>URRENTLY</u>	HAVE ANY OF	THE FOLL	OWING:			
Artificial Heart Valves	AIDS/H	AIDS/HIV Positive		Psychiatric Care		Dental Phobic	
Aspirinmg	Cardiac Transplant		Blood Thinners		Liver Disease		
High Blood Pressure	High Cholesterol		Tobacco Habit		Pace Maker		
Seizures or Fainting	Hard of Hearing		Hemophilia		Pregnant		
Congenital Heart Disease	Thyroid Disease		Dementia		Asthma		
Previous Infectious Endocarditis	Kidney Disease		Cancer		Stroke		
Mitral Valve Prolapse with Regurgitation Hepatitis			A B	C	M	IRSA	
Bone Replacement Meds - Date:			Other	:			
Artificial Joints:	Date:		I	Diabetes:	Type 1	Type 2	
Have your ever had an adverse r	eaction to a m	edical or dental p	rocedure?	NO	Y	ES	
If yes, please explain:							
Is the patient currently taking	any medicatio	ons (INCLUDINC	OVER THE	COUNT	ER & HEA	LTH FOOD	
SUPPLEMENTS?) Please list: _							
Does the patient have any drug a	allergies? Y	ES NO If YES	, please descr	ibe:			
I have reviewed the information read and understand the notice whether paid or not by insur every 3 to 5 years; depending a year. A fee of \$57/hour is chwithout 24 hour notice.	of practices. I ance. All pat their oral and	l understand tha tients are requir d medical health	nt I am financed to take fu Bitewing x-1	cially resp Ill mouth rays are re	onsible for series x-ra equired mi	r all charges ys or FMX, nimum once	
Signature:			Dat	e:/	/		