SHALLOWFORD DENTAL INC.
SANJAY PATEL, D.M.D.
DENTIST

Patient Name: _____ I prefer to be called: _____

Male Female Birth date: _____/_____/_____ SSN _____ Marital Status _____

Email _____ Home Phone #_____Mobile/cell # _____

Street/City/State/Zip _____

Employer Name _____ Office phone #_____

Employers address _____

Who may we thank for referring you? _____

Emergency Contact _____ Relationship _____ Phone _____

Person Responsible for account (only if patient is a minor or disabled):

Name _____ Phone _____

Street/City/State/Zip_____

Employer name/address _____

Birth date _____/_____/_____ Relationship to patient _____

I agree to be financially responsible for the above patient _____

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HEALTH HISTORY Circle Y for Yes or N for No if you have had any of the following:

Do you have a personal physician? Yes No
Physician's name_____
Phone #_____ Last visit_____
In the event of an emergency, who do we call:
Name_____ Relation_____
Home #_____ Office #_____
Are you currently under the care of a physician? Yes No
Which condition/s?_____
Have you had any SURGERY within 6 weeks? Yes No
Explain _____

MEDICATIONS

Are you currently taking prescription or over-the-counter drugs or herbal supplements? Yes No
Please list here: _____
_____
Are you on aspirin therapy? Yes No

AIDS/HIV	Y	N
ANEMIA	Y	N
ARTHRITIS OR RHEUMATISM	Y	N
ARTIFICIAL HEART VALVES	Y	N
ARTIFICIAL JOINTS	Y	N
ASTHMA	Y	N
BACK PROBLEMS	Y	N
BLEEDING ABNORMALLY	Y	N
BLOOD DISEASE	Y	N
CANCER	Y	N
CHEMICAL DEPENDENCY	Y	N
CHEMOTHERAPY	Y	N
CIRCULATORY PROBLEMS	Y	N
CONGENTIAL HEART LESIONS	Y	N
CORTISONE TREATMENTS	Y	N
COUGH, PERSISTENT OR BLOODY	Y	N
DIABETES	Y	N
EMPHYSEMA	Y	N

Have you taken any of the groups of drugs collectively known as "fen-phen"? Yes No

Do you take Ginger, Ginseng, Ginko Biloba, and/or Garlic?
Which? _____
Pharmacy Name and phone # _____
_____

WOMEN ONLY

Are you pregnant? Yes No Week _____
Are you taking birth control pills? Yes No
Are you nursing? Yes No

ALLERGIES

Aspirin	Yes	No	Local Anesthetic	Yes	No
Codeine	Yes	No	Penicillin	Yes	No
Latex	Yes	No	Sulfa	Yes	No
			Erythromycin	Yes	No

Other: _____

Do you require premedication with antibiotics before dental treatment? Yes No

For what condition? _____

Do you or have you ever used:

□ Tobacco? Frequency? _____

□ Alcohol? Frequency? _____

□ Controlled Substances? _____

EPILEPSY	Y N
FAINTING/DIZZINESS	Y N
GLAUCOMA	Y N
HEADACHE	Y N
HEART MURMUR	Y N
HEART PROBLEMS	Y N
HEPATITIS, TYPE _____	Y N
HERPES	Y N
HIGH BLOOD PRESSURE	Y N
JAUNDICE	Y N
JAW PAIN	Y N
KIDNEY DISEASE	Y N
LIVER DISEASE	Y N
LOW BLOOD PRESSURE	Y N
MITRAL VALVE PROLAPSE	Y N
NERVOUS PROBLEMS	Y N
PACEMAKER	Y N
PSYCHIATRIC CARE	Y N
RADIATION TREATMENT	Y N
RESPIRATORY DISEASE	Y N
RHEUMATIC FEVER	Y N
SCARLET FEVER	Y N
SHORTNESS OF BREATH	Y N
SINUS TROUBLE	Y N
SKIN RASH	Y N
SPECIAL DIET	Y N
STROKE	Y N
SWOLLEN FEET OR ANKLES	Y N
SWOLLEN NECK GLANDS	Y N
THYROID PROBLEMS	Y N
TONSILLITIS	Y N
TUMOR (GROWTH) ON HEAD	Y N
ULCER	Y N
VENEREAL DISEASE	Y N
WEIGHT LOSS, UNEXPLAINED	Y N

DENTAL HISTORY

Last Dental Appointment _____ Reason _____

History of Gum Disease? Y N Previous Dental Experiences _____

The information on this two page registration/health history is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and/or processing of insurance benefits for which I am entitled. I will not hold my dentist, or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____ Date: _____