HEIM & CARROLL DMD LLC

Name ________________________________ Date of birth ________________ Occupation _________________

Emergency Contact: ______________________________ Phone ____________________

Name & Address of Primary Care Physician

Date of last physical exam ________________________

Allergies: Check which applies**:** ___ **NONE** ___**latex** ___ **novacaine** ___ **penicillin** ___ **metals**

___ **sulfa** ___ **aspirin** **other (list):** ____

Have you ever had

Congenital Heart Defect	Y	N	High or Low Blood Sugar	Y	N	Cancer	Y	N
Infective Endocarditis	Y	N	High Blood Pressure	Y	N	Osteoporosis	Y	N
Heart Disease	Y	N	Artificial Joints	Y	N	Radiation Therapy	Y	N
Irregular Heartbeat	Y	N	Hepatitis	Y	N	Organ Transplant	Y	N
Artificial Heart Valve	Y	N	Immune Deficiency	Y	N			
Heart Attack	Y	N	Asthma	Y	N	HIV/AIDS	Y	N
Stroke	Y	N	Emphysema	Y	N	Psychiatric Care	Y	N
Seizures	Y	N	Tuberculosis	Y	N	Anxiety	Y	N
Thyroid Disorder	Y	N	Tobacco Use	Y	N	Depression	Y	N
Bleeding Disorder	Y	N	Addictions	Y	N	Sleep Apnea	Y	N

Women: Are you currently pregnant or breastfeeding? Y N

List all hospitalizations and surgeries:

Please list any medications you are currently taking including herbs, supplements & over the counter

The above information is correct and complete to the best of my knowledge. I understand that I must inform the dentist of any non-prescription drugs & illicit drugs that I am using since they may interact with drugs given by the dentist and potentially cause health consequences which may be severe and cause permanent disability or death.

Signature ____ Date _________________

Provider initials _______