Glendale Dental Assoc. II,PC
6202 Evanston Ave.
Indianapolis, IN 46220

(317)251-0085

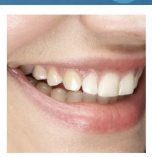
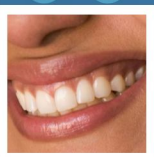
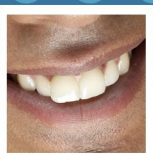

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: * _____ _____ _____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address:* _____ _____
* _____ * _____ * _____
City State Zip Code

In an emergency whom should we notify? Please enter name and phone number below:

_____

Medical Infomation

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ *Pre-Med	☐ Allergic-Amoxicillin	☐ Allergies	☐ Allergy - Sulfa
☐ Allergy- Aspirin	☐ Allergy- Codeine	☐ Allergy- Latex	☐ Allergy- Penicillin
☐ Allergy- Tylenol	☐ Allergy-Tetracycline	☐ Allg.-Erythormycin	☐ Anemia
☐ Angina/chest Pain	☐ Arthritis	☐ Artificial Joints	☐ Artificil Hrt Valve
☐ Asthma	☐ Blood Disease	☐ Cancer/Chem/Rad TX	☐ Cold Sores
☐ Coumadin	☐ Diabetes	☐ Drug/alcohol Addict	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Hay Fever

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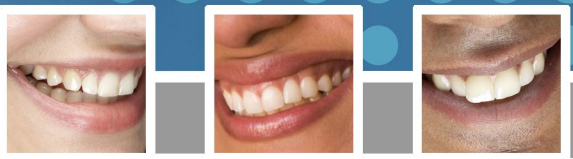

- [ ] Head Injuries
- [ ] Heart Attack/Failure
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart/Brain Stent
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Irregular Heart Beat
- [ ] Jaundice
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lung Disease
- [ ] Mental Disorders
- [ ] Mitra Valve Prolapse
- [ ] Nervous Disorders
- [ ] Organ Transplant
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Psychiatric Care
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Scarlet Fever
- [ ] See Note
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tatoos/Body Piercing
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease/STD

Is there any medical information that was or was not answered above that needs more clarification. If so please state

Do you require pre-medication with antibiotics prior to dental appointments? *

If there have been any medical changes since your last visit with us, please list below.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

* [ ] By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Response Date: