## **Klement Family Dental Care** 7650 38<sup>th</sup> Avenue North

St. Petersburg, FL 33710

(727) 343-8831 phone (727) 345-5396 fax www.StPeteDentist.com

Patient History (Adult)										
			<u>·</u>		Date: _					
Legal Name:					Sex:	$\square M$	□F			
Last Name	First Name	-	Middle Initial							
Preferred Name:										
Social Security #:		□Single	□Married	□Divo	orced	□Wic	lowed			
Address:		City:		_ State:	Zi	p:				
Home Phone: ( )	Work Phone: (	)	Cell	Phone: (	)					
Email:		Preferred Con	itact #:(please circ	le) Home	Work	Cell	Email			
Employer:										
Person Responsible for Account:_			ς	SN#:						
Home Phone: ( )										
How did you hear about our office	!?									
Emergency Contact Person:			Relation:							
Home Phone: ( )	Alternate Phone	e: ( )								
Marital Status:	Snouse's	Nama:								
Social Security #:										
30ciai 3ecuitty #										
Spouse's Employer:		Occupati	on:							
Work Phone: ( )	Cell Phone: (      )	<del>-</del>	_							
Do you have dental insurance?		Primary Ins	ured:							
Is there a secondary dental insura										
•	our insurance card to						-			
,			, , , , , , , , , , , , , , , , , , , ,							
	Medical H	History (	(Adult)							
How would you rate your health?	Excellent (	Good Fair	Poor							
Are you currently under the care of				0	YES					
If yes, please explain:										
Have you been hospitalized in the										
If yes, please explain:Name of your physician:			 }							
Address:			t complete eva	m?	_					
Audi (23).		pare or igs	r combiere exa	''':						

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	-	or have adversely i		any of the	following?	No	Yes				
" '	Aspirin	• • •	(	Codeine	Loca	l Anesthet	ic Latex				
<ul> <li>Erythromycin</li> <li>Clindomycin</li> <li>Z-Pack(Zithromycin)</li> <li>Biaxin(Clarithromycin)</li> </ul>		cycline		Penicillin . Amoxicillin . Augmentin . Ampicillin		<del></del>					
* Are	you aware of b	eing allergic to any	other medi	cation or	substance?						
* If Y	'ES, please expla	in:									
* Ple	ease list any med	lications you are cu	rrently taki	ng:							
1		2		3		4	•				
* Ha	ve vou been giv	en or have taken or	taking anv	of the fol	lowing medi	cation:					
	Fosamax	Actonel		Во	_	Aredia	Zometa				
	Alendronate)	(Risedronate)					(Pamidronate)	(Zoledronic acid)			
* Dla	aca chaolt any of	the following that	vou bava b	ad ar baw	at procent						
Pie	•	•	you nave n		•		Hepati	tic C			
	Artificial Joints (hip, knee, etc.)Mitral Valve Prolapse			Mental Retardation Stroke				Speech Problems			
Artificial Heart Valve			Stroke Asthma				Liver Disease				
	Rheumatic or Scarlet Fever				neimer's		<del></del>	Hemophilia			
	Synthetic Vascular Heart Graft				n Blood Pres	sure		Blood Transfusion			
Infectious Endocarditis				roid Disease		<del></del>	Drug Addiction				
	Hemodialysis Patients w/				ney Trouble			Arthritis			
Fistula or Shunt				iation Treati	ment	<del></del>	Diabetes				
Neuro-surgical Shunts				motherapy		<del></del>	Bruise Easily				
Portocaval Shunts				erculosis			 Epilepsy or Seizures				
Heart Murmur (Organic)				Positive			Psychiatric Treatment				
Heart Murmur (Func./Innocent)			 AID:	S			Fainting or Dizziness				
Heart Failure or Disease			ARC			Sinus 1	Sinus Trouble				
	Heart Pacemaker			Ven	ereal Diseas	e	Fever I	Fever Blisters			
Congenital Heart Lesion			Нер	atitis A		Yellow	Yellow Jaundice				
	Heart Surgery			Hep	atitis B		Hypera	Hyperactivity			
ARE Y	OU SUBJECT TO	PROLONGED BLEED	ING?	No	Yes						
		Are you taking birth			Yes	_					
		Are you pregnant?	•		Yes						
		PATIENT'S SIGNATURE									
INIT											