



# Welcome

J. Robert Donnelly, D.D.S.  
Master of the Academy of General Dentistry  
SANMARCOSDENTAL.COM

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Birthday: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Last Visit: \_\_\_\_\_

Current health: ( ) Excellent ( ) Good ( ) Poor

Please list any medications that your child is currently taking: \_\_\_\_\_

Circle all of following conditions that you have ever been treated for:

Heart Attack	Stroke	Heart Murmur	Rheumatic fever	Anemia	Kidney Problems
Hepatitis	Jaundice	High Blood Press	Low Blood Press	Diabetes	Chemotherapy
Abnormal Bleeding	Fainting	Epilepsy/Seizures	AIDS/HIV	Cancer	Mitro Valve Prolapse
Psychiatric Problems		Tuberculosis			

Please list any other serious medical problems your child has had in the last 5 yrs? \_\_\_\_\_

Have you ever been told that your child needs antibiotics prior to dental treatment? ( ) No ( ) Yes ( ) Don't Know

Is your child allergic to any medication? ( ) No ( ) Yes – If yes please list: \_\_\_\_\_

Would you like your child to be sedated for your dental treatment? ( ) No ( ) Yes

In case of an emergency is there anyone we can call? Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of person responsible for your account: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work phone #: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Mother's Name: \_\_\_\_\_ SS # \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

Fathers Name: \_\_\_\_\_ SS #: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

Please complete BOTH sides →