



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: (____) _____ Work Phone: (____) _____ Cell/Pager: (____) _____

Birthdate: _____ Social Security #: _____ Drivers Lic #: _____

Marital Status: _____ Spouses Name: _____ E-Mail Address: _____

Employer: _____ Employer Address: _____

Personal Physician: _____ Phone #: (____) _____ Last Visit: _____

Do you smoke or use chewing tobacco? () No () Yes – if yes, how much per day? _____

Current health: () Excellent () Good () Poor Would you like to be sedated for your dental treatment? () No () Yes

Please list any medications that you are currently taking: _____

Are you currently taking any Bisphosphonate therapy medications such as Fosamax, Actonel, or Boniva? () Yes () No

If so which medication? _____

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	Drug/Alcohol Abuse
Abnormal Bleeding	Fainting	Epilepsy/Seizures	AIDS/HIV	Cancer	Chemotherapy
Psychiatric Problems		Tuberculosis			Mitro Valve Prolapse

Please list any other serious medical problems you've had in the last 5 yrs? _____

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

Are you allergic to any medication? () No () Yes – If yes please list: _____

How frequently do you have headaches? _____

Do you ever wake up with a headache? () Yes () No

Are you interested in straightening your teeth? () Yes () No

Are you interested in whitening your teeth? () Yes () No

Do you snore when you sleep? () Yes () No

Do you have sleep apnea? () Yes () No

Who can we thank for referring you to our office? _____

Do you clinch or grind your teeth? () Yes () No

Does your jaw click or pop? () Yes () No

Do you have any teeth that are sensitive to cold or sweets? () Yes () No

Please complete BOTH sides→