**Jan P. Fugal, D.D.S** **Minor**

348 Milton Avenue, Ballston Spa, NY 12020

Name (last) _____ (first) _____(middle) _____

Parent's Name _____ Parent's SSN _____

Home Address _____City _____ Zip Code _____

Preferred Phone _____ (C) (H) (W) Other Phone _____ (C) (H) (W)

Other Phone _____ (C) (H) (W) Email Address _____

Would you like appointment reminders vie text _____ or email?_____ or phone? _____

Date of Birth _____ Sex _____ Occupation _____

Who referred you to our office? _____

Date of your last Physical exam _____

Physician's Name _____ Phone _____

## PHYSICAL HEALTH

Known medical conditions_____

What medications are you taking? _____

_____

Are you allergic to any medications? (antibiotics, aspirin, codeine, Novocain, etc.) _____

_____

Are you aware of any **other** allergies? _____

Have you been hospitalized lately? _____

Do you smoke cigarettes? _____ # of packs per day _____ Chewing tobacco? _____

Have you ever been told that you **have** or **had** the following?

- chest pains ☐
- heart disease ☐
- rheumatic fever ☐
- congenital heart disease ☐
- heart murmur ☐
- high or low blood pressure ☐
  blood pressure _____
- fainting spells ☐
- kidney problems ☐
- stroke ☐
- hormonal problems (thyroid) ☐
- diabetes ☐
- liver problems (jaundice) ☐
- hepatitis ☐
- lung problems ☐
- tuberculosis ☐
- persistent cough ☐
- bruise easily ☐
- anemia ☐
- cancer or leukemia ☐
- bleeding problems ☐
- stomach ulcers ☐
- sexually transmitted disease ☐
- sinus problems ☐
- artificial joints ☐
- prosthetic valves ☐

**Please turn over and complete the other side**

## DENTAL HEALTH

Are you happy with your smile? _____ If not, what would you change? _____
When was your last dental visit? _____ How often do you brush? _____ Floss? _____
Have you ever had any serious problem associated with dental treatment in the past? _____
_____
Do you have any pressing dental concerns? _____
_____
Do you have a dry mouth or burning tongue? _____
Do your gums bleed, or feel tender or swollen? _____
Are your teeth sensitive to hot ☐ cold ☐ sweets ☐
or do they hurt while chewing ☐ ?
Do you use a hard ☐ medium ☐ or soft ☐ toothbrush?
Do you clench or grind your teeth? _____
Have you ever had local anesthetic (Novocain)? _____
Do you wear full ☐ or partial ☐ dentures?
Do you gag easily? _____
Are you nervous about dental treatment? _____
Have you had or are you undergoing orthodontic treatment? _____
Do you have any habits such as nail biting ☐ thumb-sucking ☐
pencil chewing ☐ cheek biting ☐ others? _____

**CONSENT:**

The undersigned hereby authorizes the dentist to perform all necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications and use of local anesthetic agents.

The undersigned also acknowledges that the above questions concerning the medical (physical) and dental history have been correctly answered to the best of their knowledge.

_____ date _____
Patient signature (or parent of minor)

_____ date _____
Dentist signature