Richard C. Ross, D.D.S
244 State Route 308
Rhinebeck, NY 12572
(845)876-2511

Patient Name_____ Date _____

Date of Birth_____

For the following questions, circle yes or no whichever applies. Your answers are for our records and will be considered confidential.

1. Are you in good health? Yes No
2. Has there been any changes in your general health within the past year Yes No
3. My last physical exam was on _____
4. Are you under the care of a physician? _____ Yes No
   If so, what is the condition treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the Past 5 years? _____ Yes No
7. Are you taking any medicine(s) including non-prescription medicine? _____ Yes No
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur Or rheumatic heart disease_____ Yes No
   b. Cardiovascular disease(heart trouble, heart attack, angina, coronary Occlusion, high blood pressure, arteriosclerosis, stroke) _____ Yes No
      1. Do you have chest pain upon exertion? _____ Yes No
      2. Are you ever short of breath after mild exercise or when lying down Yes No
      3. Do your ankles swell? _____ Yes No
      4. Do you have inborn heart defects? _____ Yes No
      5. Do you have a cardiac pacemaker? _____ Yes No
   c. Allergy _____ Yes No
   d. Sinus trouble _____ Yes No
   e. Asthma or hay fever _____ Yes No
   f. Fainting spells or seizures _____ Yes No
   g. Persistent diarrhea or recent weight gain _____ Yes No
   h. Diabetes _____ Yes No
   i. Hepatitis, jaundice or liver disease _____ Yes No
   j. AIDS, or HIV infection _____ Yes No
   k. Thyroid problems _____ Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. _____ Yes No
   m. Arthritis _____ Yes No
   n. Stomach ulcer or hyper acidity _____ Yes No
   o. Kidney trouble _____ Yes No
   p. Tuberculosis _____ Yes No
   q. Persistent swollen glands in neck _____ Yes No
   r. Low blood pressure _____ Yes No
   s. Sexually transmitted disease _____ Yes No
   t. Epilepsy or neurological disease _____ Yes No
   u. Problems with the immune system _____ Yes No
   v. Cancer _____ Yes No

OVER

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9. Have you had abnormal bleeding? _____ Yes No
   a. Have you ever had a blood transfusion? _____ Yes No
10. Do you have any blood disorder such as anemia? _____ Yes No
11. Have you ever had any treatment for a tumor or growth? _____ Yes No
12. Are you allergic or have you had a reaction to:
    a. Local anesthetics _____Yes No
    b. Penicillin or other antibiotics(please list)_____ Yes No
    c. Sulfa Drugs _____Yes No
    d. Barbiturates, sedatives or sleeping pills _____Yes No
    e. Aspirin _____Yes No
    f. Iodine _____Yes No
    g. Codeine or other narcotic _____Yes No
    h. Other _____ Yes No
13. Have you had any serious trouble associated with any previous dental treatment Yes No
    If so, explain _____
    _____
14. Do you have any disease, condition, or problem not listed above that you think I
    Should know about? _____ Yes No
    If so, explain

15. Are you wearing contact lenses? _____Yes No
16. Are you wearing removable dental appliances? _____ Yes No

Women

17. Are you pregnant? _____ Yes No
18. Do you have any problems associated with your menstrual period? _____ Yes No
19. Are you nursing? _____Yes No
20. Are you taking birth control? _____ Yes No

Chief Dental complaint:_____
_____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient _____ Date _____

Signature of Dentist _____ Date _____