Alana K. Macalik

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Arlington, TX 76013
817-496-7899
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Today's Date:_____

Email Address:_____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

☐ Male ☐ Female DOB:__/__/____ Age: __

Home Address:_____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Cell #:(___)_____Hm #:(___)_____

Wk #:(___)_____ Ext: _____

SS #:_____ DL #:_____

Employer:_____

Occupation:_____ How long there?__

How did you hear about our office?

_____

Other family members seen by us?

_____

Medical Information

Physician's Name_____

Phone #:(__)_____ Last visit:_____

Currently under the care of a physician? ☐ Yes ☐ No

Please Explain:_____

Pharmacy:_____ (__)_____

Dental Insurance

Insurance Co. Name, Address and Phone #:

_____

_____

_____

Group, Plan, Local or Policy #:_____

Insured's Name:_____

Relationship to Patient:_____

Insured's DOB:__/__/____

Insured's ID#:_____

Insured's Employer and Address:

_____

In the event of an emergency, who should we contact?

Name:_____

Relationship:_____

Cell/Home: (____)_____

Work: (____)_____

Drug Allergies

_____ Aspirin	_____ Acrylic
_____ Erythromycin	_____ Latex
_____ Codeine	_____ Penicillin
_____ Jewelry or Metals	_____Sulfa Drugs
_____ Dental Anesthetic	_____ Tetracycline

Other:_____

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Medical History

CHECK ALL THAT APPLY

_____ AIDS/HIV Positive
_____ Abnormal Bleeding / Hemophilia
_____ Acid Reflux / GERD
_____ Alzheimer's Disease
_____ Anaphylaxis
_____ Anemia
_____ Artificial Bones / Joints / Valves
_____ Arthritis, Rheumatism
_____ Asthma or Hay Fever
_____ Auto-Immune Disease/Immune suppressed
_____ Back Problems
_____ Blood Transfusion/Blood disease
_____ Bruise easily / excessive bleeding / Hemophilia
_____ Cancer/tumors: Type/Dates_____
_____ Chemotherapy: Dates_____
_____ Radiation: Areas/Dates_____
_____ Frequent Cough
_____ Cold sores/Fever blisters/Mouth ulcers
_____ Chest pain, Angina
_____ Congenital heart defect
_____ Crohns Disease
_____ Diabetes: Date Diagnosed: _____
Type_____
_____ Difficulty Breathing
_____ Drug / Alcohol Addiction
_____ Dry Eyes / Dry Mouth
_____ Eating Disorders
_____ Emphysema / COPD / Lung Disease
_____ Epilepsy / Seizures / Fainting Spells
_____ Excessive Thirst
_____ Glaucoma
_____ Heart Attack Year: _____
_____ Heart Murmur / Heart Disease
_____ Heart Surgery / Pacemaker
_____ Hepatitis / Liver Disease
_____ High / Low Blood Pressure
_____ High cholesterol
_____ Hives or rash
_____ Hospitalized for Any Reason
Specify:_____
_____ Hypoglycemia
_____ Irregular Heartbeat
_____ Kidney Disease/Dialysis
_____ Mitral Valve Prolapse
_____ Osteoporosis / Osteopenia
_____ Parathyroid Disease
_____ Psychological Problems
_____ Pregnant:_____ weeks / Nursing
_____ Rheumatic fever / Scarlet fever
_____ Severe / Frequent Headaches / Jaw pain
_____ Shingles
_____ Sickle Cell Disease / Traits
_____ Seasonal Allergies / Sinus Problems
_____ Stroke Year: _____
_____ Stomach Ulcers / Colitis / Intestinal Disease
_____ Surgery in the last 12 months
_____ Swollen Ankles, Feet, Hands
_____ Taken Fosamax/bisphosphonate/PhenFen
_____ Thyroid: Hypo / Hyper
_____ Tobacco use: Past / Present
_____ Tuberculosis (TB)
_____ Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

_____

_____

_____

Drug Allergies:

_____ Aspirin
_____ Erythromycin
_____ Codeine
_____ Jewelry or Metals
_____ Dental Anesthetic
_____ Acrylic
_____ Latex
_____ Penicillin
_____Sulfa Drugs
_____Tetracycline

OTHER:_____

_____

Please list all prescription, over-the-counter medications or supplements you take:

_____

_____

_____

The information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment with my informed consent.

_____

Signature Date