

Gregory J. Moegling, D.D.S.

General Dentistry

Patient Information

New Patient

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____

Phone (Home): _____ Mobil/Cell: _____ (Work): _____ Ext: _____

In case of Emergency, contact: Name _____ Phone _____ Relation _____

Address: _____
Street Apartment #

City State Zip Code

Health Information

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last x-rays: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tobacco Usage |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse (MVP) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Antibiotics Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | Due: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Prescribed Weight Loss Med | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Other Anesthetic Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Are you taking any medications? Please List: _____

Do you pre-medicate for dental appointments? Yes No If so, why _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

SIGNATURE: _____ Date: _____