ELLIS K. LIST, D.D.S., P.A.
COMPREHENSIVE & ESTHETIC DENTISTRY

1020 BROAD STREET, DURHAM, NC 27705-4144 • 919.682.5327 • DRLIST1014@AOL.COM

WELCOME TO OUR OFFICE

Today's Date:_____

NAME: Mr-Mrs-Ms-Dr _____ **Male Female**
I prefer to be called:_____ **Single Married Divorced Separated**
Birthdate:_____/____/_____ **SS#** _____

Home Address: _____**Apt #**_____
_____

Phone: home (___)_____ **work (___)**_____ **cell (___)**_____
Email Address:_____

Employer Name:_____
Employer Address:_____
_____

Occupation: _____ **How long there?** _____
Best times to reach you _____ **What method?** _____

Whom may we thank for referring you?_____
Which other family members are seen by us: _____

Previous Dentist Name:_____ **Last visit date:**_____

Spouse Name: _____ **work (___)**_____ **cell (___)**_____
Employer Name: _____ **Birthdate:** _____/____/____

Person Responsible for Account: _____ **Relation:** _____
Billing Address: _____**Phone: home (__)**_____
_____**Phone: work (__)**_____

Do you have Dental Insurance? NO YES Please provide card.

In an emergency, who should we contact? Name: _____
Relation: _____ **Phone: home (___)**_____ **work (___)**_____ **cell (___)**_____

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MEDICAL HISTORY

Do you have a personal physician? NO YES Name: _____
Office phone: (___)_____ Date of last visit: _____ Condition treated:_____

Is your current physical health: GOOD FAIR POOR
Are you taking any prescription, over-the-counter, or herbal supplement drugs? NO YES
Please list:_____
_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/ Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer /Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis Type: A B C D E
Y N Herpes/ Fever Blisters
Y N High Blood Pressure
Y N HIV+/ AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

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Are you allergic to any of the following?

Y N Aspirin	**Y N Erythromycin**	**Y N Metals**
Y N Codeine	**Y N Jewelry**	**Y N Penicillin**
Y N Dental Anesthetics	**Y N Latex**	**Y N Tetracycline**

Please list any other drugs/materials that you are allergic to:_____

Have you ever taken Fosamax or any other bisphosphonate? **NO YES**
Have you ever taken Phen-fen? **NO YES**
For women, are you using a prescribed method of birth control? **NO YES**
For women, are you pregnant? **NO YES** **Week #** _____
For women, are you nursing? **NO YES**

DENTAL HISTORY

Why have you come to see us today? _____
Do you require antibiotics before dental treatment? **NO YES**
Are you currently in pain? **NO YES** **Where:**_____
Have you ever had a serious or difficult problem associated with dental work? **NO YES**
Please explain:_____
Your current dental health is: **GOOD FAIR POOR**
How many times a day do you floss? _____ **How many times a day do you brush?** _____
Are the bristles of your toothbrush: **SOFT MEDIUM HARD**
Do you smoke or use tobacco is any other form? **NO YES** **What form:**_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ **Date:**_____

FOR OFFICE USE ONLY:
I have verbally reviewed the medical/dental information above with the patient names herein.

Doctor initials: _____ **Date:** _____