Marcia L. Blazer, D.D.S., P.C.

Phone: 480.596.8273

Patient Name_____ Today's Date _____

Home Phone _____ Work Phone _____

Email _____ Cell Phone _____

Address _____

City _____ State _____ Zip_____

Have you ever, or do you have, any of the following? Please check Yes or No for each item and provide the date of occurrence or diagnosis.

	YES	NO	DATE
Acid Reflux/GERD	❑	❑	
AIDS/HIV	❑	❑	
Anemia	❑	❑	
Anxiety	❑	❑	
Artificial Heart Valve	❑	❑	
Artificial Joint	❑	❑	
Asthma	❑	❑	
Bipolar	❑	❑	
Bleed or Bruise easily?	❑	❑	
Cancer/Radiation/Chemo	❑	❑	
Chest Pain/Angina	❑	❑	
Depression	❑	❑	
Diabetes (Type 1 or Type 2)	❑	❑	
Emphysema/COPD	❑	❑	
Epilepsy/Seizures	❑	❑	
Fainting/Dizziness	❑	❑	
Fibromyalgia	❑	❑	
Heart attack	❑	❑	
Heart murmur/MVP	❑	❑	
Heart surgery	❑	❑	
Hepatitis (A, B or C?)	❑	❑	
Herpes/Shingles	❑	❑	
High Blood Pressure	❑	❑	
Kidney disease	❑	❑	
Liver disease	❑	❑	
Low Blood Pressure	❑	❑	
Schizophrenia	❑	❑	
Sinus problems	❑	❑	
Sleep apnea or CPAP	❑	❑	
Stroke	❑	❑	
Thyroid disease	❑	❑	

Please elaborate on any "Yes" responses:

Are you allergic to, or have you ever had a reaction to: (please check Yes or No for each one)

	YES	NO		YES	NO		YES	NO
Local anesthetic (numbing medication)	❑	❑	Penicillin	❑	❑	Latex	❑	❑
Codeine or other narcotic medication	❑	❑	Aspirin	❑	❑	Sulfite Preservative	❑	❑
Antibiotic	❑	❑	Other	❑	❑	Any Dental Materials	❑	❑

Please list ALL medications you are currently taking (including supplements and over-the-counter medications)

Are you on dialysis? YES ❑ NO ❑

If you are female, are you pregnant? YES ❑ NO ❑

Nursing? YES ❑ NO ❑ Taking birth control pills? YES ❑ NO ❑

Please list any medical procedures/surgery in the last 2 years:

Do you have a history of drug or alcohol abuse? YES ❑ NO ❑

Do you have any disease, condition or problem that is not listed above?

Do you typically premedicate with antibiotic before dental appointments? YES ❑ NO ❑

Dental History

Are you having any trouble with your mouth or teeth today? YES ❑ NO ❑
Please describe:

Insurance Information

Has your insurance changed since your last visit? YES ❑ NO ❑
Insured Person _____
Full Name of Insurance Company _____
Insured's Date of Birth _____
Insured's Employer _____ Insured's Social Security #_____
Group Number _____

Signature of Patient or responsible party

Thank you for taking the time to update our records regarding your health!