DENTISTRY IN FRISCO

CATHERINE KOO, D.D.S.

GENERAL & COSMETIC DENTISTRY

Patient Name____Date of Birth_____________

Name Patient prefers to go by____

Home Address_____________________________________City/State______________________

Zip_________________DL #_________________________SS #____________________________

Employer______________________________ Date of Last Dental Visit_______________________

Home Phone____________________________ Work Phone_______________________________

Cell Phone____________________________ E-mail______________________________________

Do we have permission to contact you via email? Yes □ No □

How were you referred to our office?____

		Circle	
1.	Do you have any medication or drug allergies (ie. penicillin, aspirin, codeine) ? Please list.______________________________	Yes	No
2.	Do you have any non-medication allergies (such as latex, dye, food) ? Please list.______________________________	Yes	No
3.	Have you had any excessive bleeding requiring special treatment? Please explain.______ ______________________________	Yes	No
3.	Have you been hospitalized in the past two years? ______________________________	Yes	No
4.	Are you currently taking any medication or drugs? Please list. ______________________________	Yes	No
5.	Have you had any complications following dental treatment?______________________________	Yes	No

6. Do you use tobacco? Yes/No, Frequency:________ Alcohol? Yes/No, Frequency:______________

7. Female patients: Is there any possibility you are pregnant? Yes No
8. What is your main concern that brought you to see the dentist?

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Circle any of the following conditions you currently have or had in the past:

AIDS	Bruise Easily	Hemophilia	Radiation Treatment
Bleed Easily	Congenital Heart Lesions	Heart Disease/Attack	Rheumatic Fever
Allergies	Chemotherapy	High Blood Pressure	Sinus Trouble
Anemia	Cortisone Medication	Heart Pacemaker	Sickle Cell Disease
Angina Pectoris	Glaucoma	Heart Surgery	Stroke
Arthritis	Diabetes	Hepatitis	Rheumatism
Artificial Heart Valve	Drug Addiction	Hay Fever	Nervous Disorder
Artificial Joint	Emphysema	Kidney Disease	Thyroid Disease
Asthma	Epilepsy or Seizures	Liver Disease	Tuberculosis
Blood Transfusion	Fainting or Dizzy Spells	Psychiatric Treatment	Ulcers
Family history of Diabetes	Family history of Hypertension		

Please detail anything not yet mentioned in your medical history:_______________________________
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To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health or medicines, I will inform the doctor of dentistry at the next appointment.

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Signature of Patient / or Legal Guardian (if patient is under 18 YO) Date