

REID ELATRACHE, D.M.D.
PRACTICE LIMITED TO ENDODONTICS

DATE: _____

NAME: _____ S.S.#: _____

ADDRESS: _____ CITY _____ ZIP _____

HOME PHONE _____ WORK _____ DATE OF BIRTH _____

AGE: _____ WEIGHT: _____ HEIGHT: _____

DENTAL INSURANCE: _____ PHYSICIAN: _____

REFERRED BY: _____ LAST COMPLETE PHYSICAL _____

What is your general state of health? _____

Are you now, or have you recently been under a physician's care? _____

Reason? _____

Are now taking or within in the past 6 months have you taken any drugs or medications? _____

Names? _____

Have you ever had a serious illness or operation? _____

Do you have any allergies? _____ To what? _____

Have you ever had a reaction to a local anesthetic, antibiotic, or other drugs? _____

Are you pregnant? _____ Month? _____

Have you ever had Hepatitis or been jaundiced? _____

Are you HIV positive? _____

Have you ever had a venereal disease?(Gonorrhea or Syphilis) _____

Are you able to perform your daily duties without stress or strain? _____

Are your activities limited for any reason? _____

Have you ever had any chest pains or shortness of breath? _____

Have you ever been told that you had a heart murmur, heart trouble or lung trouble? _____

Have you ever had prolonged bleeding following a cut, tooth extraction or other injury? _____

Have you ever been told you were Anemic? _____

Have you ever had a convulsion or a seizure, or do you get frequent headaches? _____

Are you diabetic? _____ How long? _____ Treatment: _____

Is there a history of tuberculosis, diabetes or bleeding in your family? _____

Do you smoke and/or drink? _____