

Dr. Mark A. Tromblay

Name: Mr. Mrs. Ms. Dr. _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Address: _____

E-mail Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Employed by: _____ Occupation: _____

Business Address: _____

Spouse's Name: _____

In case of emergency whom should we notify? Name: _____ Phone: _____

Whom may we thank for referring you? _____

Special interests, sports, hobbies, etc. _____

Do you have dental insurance? _____

MEDICAL HISTORY

Name and Address of your Physician: _____

Physician Phone: _____

Date of your last complete exam: _____ Have you been hospitalized in the last 2 years? _____

Do you have or have you had any of the following? (Please circle)

Abnormal Heart Problems	Congenital Heart Disease	Hepatitis (type _____)	Persistent Cough
Abnormal Blood Pressure	Diabetes (type _____)	Joint Replacement	Psychiatric Care
AIDS or HIV positive	Epilepsy	Kidney Disease	Radiation Treatments
Anemia	Fainting Spells	Liver Disease	Rheumatic Fever
Arthritis (type _____)	Easy Bruising	Measles	Stroke
Artificial Heart Valves	Emphysema	Mitral Valve Prolapse	Sinus Problems
Asthma	Gastritis	Mumps	Stomach Ulcers
Cancer (type _____)	Gout	Nasal Obstruction	Substance Abuse
Cardiac Pacemaker	Heart Attack	Neurologic Disorder	Thyroid Disorder
Circulatory Problems	Heart Murmur	Osteoporosis	Tonsillitis
	Heart Surgery		Tuberculosis

Are you allergic to: Penicillin _____ Codeine _____ Local anesthetics _____ Latex _____ Sulfa drugs _____

Please list any other allergies: _____

List all medication &/or herbal supplements you are taking: _____

Women: Are you pregnant? _____ Nursing? _____

Consent for services

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment for all dental services. Balances over 90 days will be charged 1.5% per month (18% per annum) interest. Also, if your account is turned over to a collection agency, a delinquency fee of 20% of the unpaid balance will be added to your account. I give permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature of Patient or Guardian _____ Date: _____