

***Dr. David Claffey IV, DDS, MS***

***Dr. Elizabeth Claffey DDS, MS***

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_-\_\_-\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_-\_\_-\_\_\_\_**

***Nickname*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WorkPhone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If Dental Insurance is not in your name, list ***name & birth date*** of person responsible:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFO**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* You should have received a copy of our HIPPA compliant “Notice of Privacy Practices”**

**\* I acknowledge receipt of the included Notice of Privacy Practices for this office.**

| \* |  |
| --- | --- |

**Signature Date**

**Please rate your anxiety level regarding today's appointment: (circle one)**

*NOT Anxious VERY Anxious*

***1 2 3 4 5***

Have you ever had any of the following medical conditions? (check all that apply)

| \_\_ Heart Attack | \_\_ Tuberculosis (TB) |
| --- | --- |
| \_\_ Stroke | \_\_ Cancer/Chemotherapy |
| \_\_ Heart Surgery | \_\_ Compromised Immune System |
| \_\_ Pacemaker | \_\_ Joint Replacement |
| \_\_ Arrythmia/ Atrial fibrillation | \_\_ Infection following a joint replacement/surgery |
| \_\_ Cardiac valve replacement | \_\_ Diabetes- Controlled\_\_ Uncontrolled\_\_ |
| \_\_Transcatheter Aortic valve replacement | \_\_ Last AIC if Diabetic |
| \_\_ Cardiac Transplant | \_\_ Osteonecrosis of Jaw |
| \_\_ Previous Infective Endocarditis | \_\_ History of Bisphosphonates medication use |
| \_\_ Organ Transplant | Actonel, Fosamax, or Zometa |
| \_\_ Rheumatic Fever/Rheumatic Heart Disease | \_\_ Asthma |
| \_\_ High Blood Pressure | \_\_ Sinus Problems |
| \_\_ Low Blood Pressure | \_\_ Epilepsy/Seizures |
| \_\_Cerebral Shunt | \_\_ Drug/Alcohol Abuse |
| \_\_ Anemia | \_\_ Psychiatric problems |
| \_\_ Abnormal Bleeding/Hemophilia | \_\_ Fainting Spells |
| \_\_ Chronic Hepatitis | \_\_ Panic attacks |
| \_\_ HIV/Aids |  |

Have you ever experienced any medical conditions not listed? \_\_\_\_\_\_ If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ***allergic*** to any of the following?

\_\_ Penicillin \_\_ Aspirin

\_\_ Household Bleach \_\_ Latex

\_\_ Dental Anesthetics \_\_ Codeine

Please list any other ***allergies***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the ***care of a physician***? \_\_\_\_

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any ***medications*** prescribed by a ***physician or dentist***:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ***pregnant*** or ***nursing***? If yes, week # \_\_\_\_\_\_\_\_

**AGREEMENT**

\* I understand that the information 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 history.

|  |  |
| --- | --- |

**Signature Date**