Kevin Calzonetti & Associates

ENDODONTISTS

Kevin Calzonetti B.A., B. Ed., D.D.S., D. Endo., F. R. C. D. (C)

Our reputation is rooted in your smile

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Name:______________________________ Date: ______________

Date of Birth (mm/dd/yy):______________________________

Please Circle

1. Have you ever had a serious illness, operation, or been in the hospital? YES NO
   If yes, explain ______________________________

2. Are you currently being treated for any medical condition? YES NO
   If yes, explain ______________________________

3. Have you had a medical examination in the last year? YES NO
   If yes, any medical problems ______________________________

4. Are you presently taking any medications? YES NO
   If yes, please list them ______________________________
   ____

5. Do you have or have you ever had any of the following?

❑ Rheumatic Fever	❑ Heart Attack	❑ Pacemaker	❑ Cancer	❑ Gastrointestinal Disease
❑ Liver Disease	❑ Kidney Disease	❑ Blood Disorder	❑ High Blood Pressure	❑ Heart Murmur
❑ Jaundice	❑ Lung Disease	❑ Asthma	❑ Anemia	❑ AIDS
❑ Hepatitis	❑ Epilepsy	❑ Radiation	❑ Sinusitis	❑ Joint Replacement
❑ Thyroid Disease	❑ Diabetes	❑ Therapy	❑ Venereal Disease	❑ Mental or Nervous Disorder

❑ Other (please explain)______________________________

6. Are you allergic to any medication? YES NO
   If yes, explain ______________________________

7. Do you have any allergies or sensitivities? YES NO
   If yes, explain ______________________________

8. Do you require antibiotics before all dental procedures? YES NO
   If yes, reason ______________________________

9. Do you bleed abnormally? YES NO

10. WOMEN: Are you pregnant or trying to get pregnant? YES NO
    If you are pregnant, which trimester ______________________________

11. Is there anything that the dentist should know regarding your medical history that has not been mentioned? YES NO
    If yes, explain ______________________________

PLEASE READ THE CONSENT FORM AND SIGN IT AT THE RECEPTION DESK ON THE SIGN PAD