Ferguson DENTAL CARE
A happy place for healthy smiles

Paul Ferguson, DMD / Dorothy Hoyt-Rehm, DMD
Patient Profile

General Information

Name _____ Date of Birth _____

Address _____ Home Phone _____

_____ Work Phone _____

Email _____ Mobile Phone _____

Preferred contact: ☐ email ☐ text ☐ phone _____ (specify which one if multiple)

Dental Insurance: ☐ none ☐ Ins Company_____ Group #_____ ID#_____

Medical History

Your Physician's Name _____ Physician Phone _____

Have you been seen by your physician during the last 2 years? ☐ Yes ☐ No

Have you been hospitalized during the last 2 years? ☐ Yes ☐ No

Are you allergic to Penicillin? ☐ Yes ☐ No Are you allergic to Latex or Acrylic? ☐ Yes ☐ No

Please list any other drugs to which you are allergic: _____

Please check any of the following conditions that you have, or have had in the past:

☐ Rheumatic Fever	☐ Heart Disease	☐ Heart Murmur	☐ Mitral Valve Prolapse
☐ Heart Surgery	☐ Cancer	☐ Stroke	☐ High/Low Blood Pressure
☐ AIDS	☐ HIV Positive	☐ Diabetes	☐ Seizures
☐ Hepatitis	☐ Tuberculosis	☐ Arthritis	☐ Fainting
☐ Pacemaker	☐ Asthma	☐ Artificial Joints/Pins/Implants	

Please list all medications that you take (include prescription and non-prescription drugs, herbal remedies, etc.):

_____

Have you ever had a problem with prolonged bleeding? ☐ Yes ☐ No

Do you see a gastroenterologist? ☐ Yes ☐ No Do you have GERD (reflux)? ☐ Yes ☐ No

Have you ever undergone Radiation or Chemotherapy? ☐ Yes ☐ No If yes, please describe the specific area treated: _____

Have you ever taken any bisphosphonate medication (e.g. for osteoporosis or with chemotherapy)? ☐ Yes ☐ No

Do you have any of the following symptoms: productive cough, coughing up blood, unexplained weight loss, loss of appetite, lethargy/weakness, night sweats, or fever? ☐ Yes ☐ No If yes, please describe:

_____

_____

Females: Are you pregnant or nursing? ☐ Yes ☐ No

Do you get recurrent attacks of herpes labialis (fever sores) on your lips? ☐ Yes ☐ No

Please describe any other medical condition(s) that you feel your dentist should know about:

_____

Signature: _____ Date: _____

Updates *(for office use only)*

Changes? ☐ Yes ☐ No Date _____ Initials _____

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