Dr. Cary Galler
D.D.S., M.S.D.

Patient Information & Medical Questionnaire

Contact Information

Last Name:______________________ First Name:______________________
Birthday: *Day* ______ *Month* ______ *Year* ______ Preferred Salutation: Mr. Mrs. Miss. Ms. Dr.
Address:______________________ Suite #:______________________
City:__________ Postal Code:__________ Email:__________
Home #:__________ Work #:__________ Cell #:__________
Current Occupation:______________________ Employer:______________________
Emergency Contact:______________________ Relationship:______________________
Contact Phone #1:______________________ Contact Phone #2:______________________

Health Providers

Who referred you to our office *(if other than your dentist)?*______________________
Who is your dentist?______________________ Phone #:__________
How long has he/she been your dentist?__________years

Who is your medical doctor?______________________ Phone #:__________
Do you see any other medical specialist? If so, what specialty?______________________
Specialist's Name:______________________ Phone #:__________

Insurance Information

Primary Insurance Company:______________________
Group / Plan / Contract #:______________________ ID / Certificate #:______________________

Secondary or Spousal Insurance Company:______________________
Name *(of Policy Holder)*:______________________ Birthdate *(of Policy Holder)*:__________*(dd/mm/yyyy)*
Group / Plan / Contract #:______________________ ID / Certificate #:______________________

Your Comfort

On a scale of 1 to 10, 1 being not very nervous and 10 being very nervous, how nervous are you about today's visit? *(Please circle a response)*

1 2 3 4 5 6 7 8 9 10

Is there anything we can do to make your visit more comfortable for you? Please let us know.

____
____

Please review and sign:
To the best of my knowledge, the above information is complete and accurate:

Signature:______________________ Date:______________________

Continued on reverse…

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Medical Alerts

Please answer the following medical questions:

Yes	No	Question
☐	☐	Do you regularly use alcohol? If so, how much do you consume per day? ________________
☐	☐	Do you use non-prescription drugs? If so, how often? ________________
☐	☐	Do you take blood thinners or daily aspirin? Which? Dose? ________________
☐	☐	Do you take medication for osteoporosis or any bisphosphonates? Dose? ________________
☐	☐	Do you require Prophylactic Antibiotics (Pre Medication) for dental/surgical care?
☐	☐	Are you allergic to any medications? Which? ________________
☐	☐	Are you allergic to latex?
☐	☐	Do you have difficulty with local anesthetic?
☐	☐	Do you smoke? How may cigarettes/day? ________________
☐	☐	Do you suffer from obstructive sleep apnea?
☐	☐	Have you been hospitalized in the last 15 years? For what reason? ________________
☐	☐	Have you recently experienced unintentional weight loss?
☐	☐	Do you have any dental implants in your mouth?
☐	☐	Do you clench or grind your teeth?

Medical Conditions

Circle any of the following conditions that you currently suffer from:

Allergies / Hay Fever	Edema	Jaundice	Seizures / Epilepsy
Angina	Excessive urinating	Kidney trouble	Sickle Cell Anemia
Anemia	Glaucoma	Liver trouble	Sinus problems
Arthritis	Head injury	Low Blood Pressure	Stroke
Asthma	Hearing problems	Nervous disorder	Tuberculosis (TB)
Bleeding Problems	Heart Attack	Parathyroid	Thyroid
Cancer	Heart Murmur	Pneumonia	Tumour / growth
Cardiac pacemaker	Hepatitis	Prostate disorder	Ulcers
Chest Pain	High Blood Pressure	Prosthetic Valve	Venereal Disease
Chronic Fatigue	HIV / AIDS	Rheumatic fever	Vision problems
Diabetes	Hives / Rashes		

For Females Only

Are you pregnant?
Yes No
Due Date?
____

Are you nursing?
Yes No

Do you take birth control?
Yes No

Do you take osteoporosis medications?
Yes No

Please list any medications AND dose you are currently taking or elaborate on any medical condition highlighted above:

____

____

Please review and sign:

Signature:________________________________ Date:________________

For Office Use Only: Key Medical Info or Contributing / Critical Risk Factors to be included in report