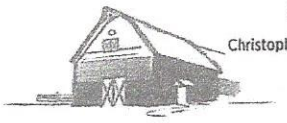

RED BARN DENTAL
Christopher Armento, D.M.D. | Lisa Indelicato, D.M.D.
361 Kings Hwy E.
Middletown, NJ 07748
732.671.1110

Today's Date: _____

PLEASE LEAVE NO BLANKS

Name: _____ DOB: _____ Sex: ____ SS#: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
Name of Spouse (If minor, Parent): _____ Guarantor: _____
Employer: _____ Work Phone #: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Full Time Student: ☐ Yes ☐ No – Where: _____

Dental Health History:

What brings you in today? (ex: pain, checkup, etc.) _____
Last Dental Visit: _____ Last Date of Cleaning: _____
Are you nervous about seeing a dentist? ☐ Yes ☐ No – If yes, please tell us why: _____
How often do you brush: _____ Do you floss: ☐ Yes ☐ No – How often?: _____
Is there anything about the appearance of your teeth you would like to change? _____

(Please circle yes or no)

Y N I clench or grind my teeth during the day/night
Y N My gums bleed when I brush/floss
Y N I want my teeth whiter
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N I have problems eating
Y N I have had a facial or jaw injury
Y N I want my teeth straight

Medical Health History:

Do you or have you ever had any of the following? (Please circle yes or no)
Are you under a PHYSICIANS care now? Y N - If yes, why: _____
Physician's Name: _____ Office Phone #: _____

Y N Heart Disease
Y N Heart Murmur/Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Cough that produces Blood
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Cancer/Chemotherapy
Y N History of Drug Addiction
Y N Immune Suppressed Disorder
Y N Implants/Artificial Joints: _____
Y N Smoke/ Use Tobacco; per day: _____ how many years: ____
Y N Drink Alcoholic beverages: per day: _____ per week: _____
Y N Usually take antibiotic prior to dental treatment
Y N Glaucoma
Y N Liver/Kidney Disease
Y N Jaundice
Y N Hepatitis Type: ____
Y N Diabetes: Type 1 or Type 2
Y N Excessive Urination and/or Thirst
Y N Ulcers
Y N Herpes
Y N Arthritis
Y N Sexually Transmitted/Venereal Disease
Y N History of Emotional or Nervous Disorders
Y N Radiation Treatment
Y N AIDS/HIV
Y N Hearing Loss

PLEASE COMPLETE BACK PAGE

Y N Have had major surgery:

Year: _____ Type of Operation: _____

Year: _____ Type of Operation: _____

Y N Any other problem or medical history NOT listed on this form? _____

WOMEN: Y N Are you taking birth control medication

Y N Are you or could you be pregnant or nursing

Allergic to any of the following?

Y N Aspirin

Y N Ibuprofen

Y N Penicillin

Y N Acetaminophen (Tylenol)

Y N Sulfa Drugs/Sulfites/Sulfides

Y N Codeine

Y N Erythromycin

Y N Local Anesthetic

Y N Latex, Metals, Plastics

Y N Other Medications - _____

Please list any medications you are currently taking & dosage:

_____ for treatment of: _____

_____ for treatment of: _____

_____ for treatment of: _____

_____ for treatment of: _____

_____ for treatment of: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Signature of Patient/Legal Guardian: _____ **Today's Date:** _____

For completion by Dentist/Dental Professional:

_____

_____

_____

_____