Howard W. Tolk, D. D. S. & Vernon D. Dommu, D.M.D., P.C.

Patient's Name: _____ **D.O.B.:**____/____/____ **SSN:**_____-_____-_____
Patient's Address: _____ **Phone #:**_____ **Cell #**_____
City: _____ **ST:** _____ **ZIP:**_____ **Email (To Confirm)**_____
What number do you wish us to use to confirm your appointments?_____
Employer Name:_____ **Work Phone#**_____ **Okay to call at work?**
Yes No

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THESE ILLNESSES

- ❑ Aids/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Chronic Cough
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems or Surgery
- ❑ Hepatitis Type___
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lyme Disease
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Special Diet
- ❑ Spinal or Neuro surgery
- ❑ Disc replacement surgery
- ❑ Stroke
- ❑ Swollen Feet or Ankles
- ❑ Swollen Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Weight Loss, unexplained
- ❑ Other_____

Are You Taking :
Coumadin___Yes___No
Plavix?___Yes___No
Fosamax?___Yes ___No
Biophosphonates?___Yes __No

Consume Alcohol Daily?
_____Yes _____No

Smoke Tobacco?

_____Yes _____No

Women: Are you pregnant? Yes No Due Date: _____ Are you taking oral contraceptives? _____

Primary Care Physicians Name:_____ (please print)
(Phone Number)_____-_____-_____

List Daily Medications: Including Vitamins & Cholesterol Medication:

_____

_____

Allergies: (Please Circle If Applicable) **:No Known**
Allergies: :Penicillin: :Aspirin: :Codeine: :Sulfa: :Latex: :Metal: :Novocain/ Epinephrine: Other: _____

Previous surgery or hospitalizations:
(Please include Dates)

Patient Signature: _____Date:_____

(Parent or guardian for minor child)