All Family Dental

David H. Schiff DDS
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Phone: 410-641-0334
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Patient Information

Name: _____ **Birth Date:** _____
First Last

Address: _____
Street City State Zip

Primary Phone: _____ **Secondary Phone:** _____

Emergency Contact: _____
Name/ Relationship/ Phone Number

Dental Insurance

Insurance Company: _____

- **Please present Dental Insurance Card for photocopying**

Dental History

Previous Dentist: _____ **Date of last dental visit:** _____

Mark (x) if you have had problems with any of the following

__ Clenching teeth __ Griding teeth __ Sensitivity to hot __ Sensitivity to cold

__ Bleeding gums __ Loose teeth __ Broken fillings/teeth __ Clicking or popping jaw

__ Food collection between teeth __ Pain when brushing __ Bad breath

How often do you floss? _____ **How often do you brush?** _____

Medical History

Physician's Name: _____ **Date of last visit:** _____
Have you had any serious illnesses or operations? _____
_____
_____

Are you pregnant? __ Yes __ No

Are you on Blood Thinners? __ Yes __ No If Yes, what? _____

Do you wear Dentures? __ Yes __ No

Mark (x) if you have or have had any of the following:

__ Artificial Heart Valves	**__ Artificial Joints**	**__ Hepatitis**	**__ High Blood Pressure**
__ HIV/AIDS	**__ Diabetes**	**__ Stroke**	**__ Asthma**
__ Epilepsy	**__ Kidney Disease**	**__ Cancer**	**__Tobacco Habit**
__ Pace maker	**__ Chemotherapy**	**__ Heart Attack**	**__ Jaw Pain**
__ TB or Pulmonary Issues	**__ Glaucoma**	**__ Anemia**	

Medications	Allergies
List medications you are currently taking (Or please supply a list): _____ _____ Pharmacy Name and Location: _____ _____	Please list any known allergies: _____ _____ _____ _____ _____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my Dentist or any member of staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____