# Timothy C. Rothrock DDS

1308 S Pleasant St., Springdale, AR 72764 Ph. 479-751-5071, www.smilesbyrothrock.com

**Patient Information:**

Patient Full Name _____Liked to be called _____

Address_____City_____State_____ Zip_____

Phone: (HM)_____(WK)_____ext_____ (CELL)_____

**Email**:_____ Sex: Male Female Status: Married Single Divorced Widowed Child/ Student

**Birth date**: _____ **SS#** _____ **Pharmacy**_____

Occupation_____ Place of Employment/School_____

**Contact in case of Emergency**_____ Phone_____

Whom may we thank for referring you? _____

**Please answer all questions. Answers to the following questions are for our records ONLY and will be considered confidential**

**ALLERGY: Are you allergic or have you reacted adversely to:**

**Y N** Local anesthetic
**Y N** Barbiturates, sedatives, or sleeping pills
**Y N** Codeine
**Y N** Aspirin
**Y N** Latex
**Y N** Penicillin or other antibiotics(clindamycin, keflex etc..)
**Y N** Sulfa Drugs
**Y N** Valium or other tranquilizers
**Y N** Lodine
Other_____

**Do you have any of the following? If YES check with your Medical Doctor about Pre-Medication before any treatment**

**Y N** Cardiac pacemaker, Artificial Heart Valve or Cataract
**Y N** Implants/ Artificial prosthesis( knee joints, elbow pins, etc**..)**
**Y N** Mitral Valve Prolapse
**Y N** Cardiac Stent ( within last 12 weeks)

**MEDICATIONS (please include all over the counter medications, vitamins, herbs, inhalers, eye drops & as needed medications) If list is extensive please ask for an expanded medication list**_____

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## MEDICAL HISTORY

**Y N** Are you under the care of a Physician Name of Physician(s)_____
**Y N** Has there been any change in your general health? Explain_____
**Y N** Have you ever had a serious illness or operation
**Y N** Have you been hospitalized within the last 5 years
**Y N** Have you had surgery/radiation treatment for a tumor of the head/neck
**Y N** Have you had a persistent cough/ coughed up blood
**Y N** Have you had any serious trouble associated with previous dental treatment? Explain_____

**Are you taking any of the following?**

**Y N** Antibiotics
**Y N** Anticoagulants(blood thinners such as Coumadin, Plavix, etc..)
**Y N** Medicine for High Blood Pressure
**Y N** Cortisone (steroids)
**Y N** Tranquilizers
**Y N** Aspirin
**Y N** Insulin, Tolbutamide (Orinase) or similar drug
**Y N** Immunosuppressive drugs (possibly for transplant)
**Y N** Medications for heart trouble
**Y N** Nitroglycerin
**Y N** Fen-Phen or a related drug such as lonimin, Adiphex Phentermine, Fastin, Pondimin(Fenfluramine, and Redux)
**Y N** Chemotherapy drugs
**Y N** Osteoporosis drugs (Fosomax, Aredia, Zometa, etc..)
**Y N** Any natural product, vitamin supplement or homeopathic remedy?
**Y N** Are you taking any other drug or medication for any other condition that is not listed? **If YES, what**?_____

**Do you have, or have you had, any of the following disease or problems?**

**Y N** Rheumatic fever or rheumatic heart disease
**Y N** Cardiovascular disease(heart disease, heart attack, Coronary occlusion, arteriosclerosis, stroke
**Y N** Do you have **LOW/HIGH** blood pressure
**Y N** Hepatitis(Type_____), jaundice, or liver disease
**Y N** Asthma, hay fever and/or sinus trouble
**Y N** Diabetes- Type_____
**Y N** Does your mouth frequently become dry
**Y N** Stomach ulcers
**Y N** Tuberculosis
**Y N** A tumor or growth
**Y N** Radiation therapy &/or Chemotherapy
**Y N** Heart murmur
**Y N** Pain in chest &/or short of breath after mild exertion
**Y N** BloodBornePathogen(HIV/ AIDS) or STD
**Y N** Do you have any blood disorder such as anemia
**Y N** Convulsions/ Epilepsy
**Y N** Fainting spells or seizures
**Y N** Do you urinate(pass water) more than 6 times a day
**Y N** Arthritis
**Y N** Kidney trouble
**Y N** Thyroid trouble
**Y N** Bleeding tendency/ abnormal bleeding
**Y N** Psychiatric Therapy

**Habits**

**Y N** Do you smoke
**Y N** Do you drink alcoholic beverages
**Y N** Do you take any recreational drugs

**Women ONLY**

**Y N** Are you pregnant or could be
**Y N** Are you taking oral contraceptives

Signature_____ DATE_____