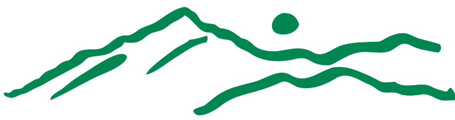

SUMMIT FAMILY DENTISTRY

RICHARD L. HARVEY, D.D.S.
AARON K. KUBICEK, D.M.D. ALISON W. HOOVER, D.D.S.

Welcome to Our Dental Office!

12999 West Bowles Drive, Littleton, CO 80127
(303) 989-9010 | Fax: (303) 989-0271 | www.SummitFamilyDentistry.com

1. The Patient

Today's Date: ______________________

Name ______________________ Preferred Name ______________________ Gender: Male or Female

Birth Date ______________________ Age ____________ SS# ______________________

Home Address ______________________ City ____________ State ______ Zip ________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________ Preferred Contact Method ______________

Employer ______________________ Occupation ______________________

Spouse's Name ______________________ Spouse's Work Number ______________

Family Members Seen Here ____

Emergency Contact ______________________________ Phone ______________

How did you hear about our office? ____

2. Medical History

Are you currently under a physician's care? Y N If so, why ______________________

Please list all current medications ____

Are you pregnant? Y N If yes, when are you due? ______________________

Do you or have you had any of the following? ***Please check circle.***

O Alzheimer's Disease	O Artificial Heart Valves	O Emphysema	O Hemophilia	O Mitral Valve Prolapse
O Anaphylaxis	O Asthma	O Epilepsy	O Hepatitis	O Psychiatric Problems
O Anemia	O Cancer	O Fainting Spells	O High/Low Blood Pressure	O Shortness of Breath
O Angina	O Cold/Fever Sores	O Glaucoma	O Infectious Disease (STD)	O Sinus Trouble
O Anxiety Attacks	O Congenital Heart Defect	O Heart Attack	O Kidney Problems	O Tuberculosis
O Artificial Bones/Joints	O Diabetes	O Heart Murmur	O Lupus	O Other ____________.

Do you have a latex allergy? Y N

Allergic to: Penicillin, Codeine, Local Injected Anesthetics. Other Allergies: ______________________

Tobacco use? Y N

Have you ever had to premedicate with an antibiotic before a dental appt.? Y N

Surgeries? What type and when ____

Have you ever taken bisphosphonates? Y N

Do you have a history of Chemical/Alcohol dependency? Y N

Any other health concerns? ____

Preferred Pharmacy ______________________________ Location ______________

The information I have given today is correct to the best of my knowledge. I have reviewed a copy of the office's Notice of Privacy Practice. I understand that I must inform the office of any changes in my medical status.

Signature ______________________________ Date ______________