PAOLUCCI FAMILY DENTIST
931 SMITH STREET
PROVIDENCE, RI 02908
PHONE: 401-521-5528 FAX: 401-521-5540

MEDICAL FORM

Patient Information

Patient Name: _____ Date: _____
Last First MI

Address: _____
Street Apt. #

_____
City State Zip Code

Social Security #: _____ Birthdate: _____ Email: _____

Phone: (Home) _____ Cell: _____ Work: _____ Ext: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Occupation/Employer: _____

In case of Emergency, contact:
Name: _____ Phone: _____

Relationship: _____

Referred By: _____

Health Information
Date of Last Dental Visit: _____
Date of Last x-rays _____
Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Alcohol/Drug Addiction
☐ Allergies
☐ * Antibiotics Allergy
Type: _____
☐ * Aspirin Allergy
☐ * Codeine Allergy
☐ * Dye Allergy
☐ * Iodine Allergy
☐ * Latex Allergy
☐ Anemia
☐ Anxiety
☐ Arthritis/Rheumatism
☐ Artificial Heart Valve
☐ Asthma
☐ Autism
☐ Bisphosphonates
☐ Blood Disease
☐ Blood Thinner
☐ Cancer
☐ Chest Pain
☐ Dementia
☐ Diabetes (Type 1)
☐ Diabetes (Type 2)
☐ Dizziness/Fainting
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Food Allergy
☐ Glaucoma
☐ Head Injuries
☐ Heart Attack
☐ Heart Defect
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A,B,C,D,E
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Hives/Skin Rash
☐ Jaw Pain (TMJ)
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Lyme Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse (MVP)
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Pregnancy
Due: _____
☐ Prescribed Weight Loss Med
☐ Radiation Treatment
☐ Recreational Drugs
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ STD's
☐ Stomach Problems/Ulcers
☐ Stroke
☐ Thyroid Disease
☐ Tobacco Use
☐ Tuberculosis
☐ Tumors/Growths
☐ Other

(PLEASE TURN OVER) PAGE 1

Please **elaborate** on the above information if necessary.

_____

_____

1. Date of last physical examination: _____

2. What is **name and address** of your **PRIMARY CARE PHYSICIAN**? _____

_____

3. Please indicate the DETAILS of your treatment with your **Primary Care Physician** and any other **Physician**.

   Indicate any HOSPITALIZATIONS within the past 5 years, etc.

Details: _____

Hospitalizations: _____

4. Are you aware of any **ALLERGIES?** _____

5. List the names of the **PRESCRIPTION MEDICATIONS, VITAMINS**, and **OVER THE COUNTER MEDICATIONS** that you take on a **Regular or As Needed Basis. Include: Blood Thinners, Birth Control Pills, Steroids and Nitroglycerin.**

_____

_____

6. Do you **PRE-MEDICATE** for dental appointments? ☐ YES ☐ NO If so, what do you take and why?

_____

WOMEN ONLY

7. **Are you pregnant?** ☐ YES ☐ NO

Consent:

The undersigned hereby authorize the Doctor to take radiographs, study models or any other diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment and prescribe medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. For women, I understand that taking antibiotics may make birth control medication less effective.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

Patient (or parent if minor child) Signature: _____ Date: _____

Dentist Signature: _____ Date: _____