WELCOME TO DR. ANNABEL BRAGANZA'S DENTAL OFFICE
PLEASE COMPLETE BOTH PAGES OF THIS FORM

Mr. ☐ Mrs.☐ Miss☐ Ms.☐ Dr.☐ ☐Adult ☐Child

Name: (Last)______________ (First)______________ (Initial)_____ Prefer to be Called: ______________

Address: ______________________________ (Postal Code)__________

Home Phone: (___) ____ - _________ Work Phone: (___) ____ - ___________ X ____ Other: (___) ___ - _______

Email:_________________________ Date of Birth: MM/DD/YY Age: ____ ☐Male ☐Female

Who may we thank for referring you? ______________________________

Your Occupation: ______________________________

Employer / School: ______________________________ Phone: (___) ___ - _______

In Case of Emergency Notify: _______________ Relationship: _____________Phone: (___) ___ - _______

Physicians Name: _______________Phone: (___) ______ - ________**Health Card** #____________________

Primary Insurance	**Secondary Insurance**
Insurance Co: ______________________ Policy/Plan #: __________ D.O.B policy holder: _______ Subscriber I.D. ______________________ Subscriber: ______________________ Relationship: ☐Self ☐Spouse ☐Other:______________ Subscriber's Address: ______________________	Insurance Co: ______________________ Policy/Plan #: __________ D.O.B. policy holder: ______ Subscriber I.D. ______________________ Subscriber: ______________________ Relationship:☐Self ☐Spouse ☐Other:______________ Subscriber's Address: ______________________

PLEASE BE ADVISED PATIENTS ARE RESPONSIBLE FOR PAYMENT ON DAY OF TREATMENT

The following information is required by Dr. Annabel Braganza to assist in proper diagnosis and Treatment.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
   ☐Yes ☐No ☐Not Sure/Maybe
   ____
2. When was your last medical checkup? ______________________________
3. Has there been any change in your general health in the past year? If yes, please explain.
   ☐Yes ☐No ☐Not Sure/Maybe
   ____
   ____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
   ☐Yes ☐No ☐Not Sure/Maybe
   ____
   ____

5. Do you have any allergies? If you answered yes, please list using the categories below:
☐ Yes ☐ No ☐ Not Sure/Maybe

a) medications
b) latex/rubber products
c) other e.g. hay fever, foods
d) Quetiapine Fumerate (Clindamycin)

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6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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7. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not Sure/Maybe

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
☐ Yes ☐ No ☐ Not Sure/Maybe

10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
☐ Yes ☐ No ☐ Not Sure/Maybe

12. Do you have any conditions or therapies that could affect you immune system
E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

14. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

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15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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16. Do you have or have you ever had any of the following? Please circle

☐ chest pain, angina ☐ shortness of breath ☐ pacemaker ☐ steroid therapy ☐ seizures (epilepsy)
☐ heart attack ☐ prosthetic heart valve ☐ lung disease ☐ diabetes ☐ kidney disease
☐ stroke ☐ tuberculosis ☐ stomach ulcers ☐ thyroid disease
☐ cancer ☐ arthritis ☐ diet pill therapy ☐ drug/alcohol dependency

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ Yes ☐ No ☐ Not Sure/Maybe

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18. Are there any diseases or medical problems that run in your family? E.g. diabetes, cancer or heart disease
☐ Yes ☐ No ☐ Not Sure/Maybe

19. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe

20. Are you nervous during dental treatments? ☐ Yes ☐ No ☐ Not Sure/Maybe

21. **For women only**: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? _____________
☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: ____ **Date:** ________________________

Dentist Signature:____ **Date:** ________________________

IF UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE 2 BUSINESS DAYS NOTICE SO A CANCELLATION CHARGE WILL NOT HAVE TO BE MADE.

PATIENT SIGNATURE: ____ **DATE:** __________________