Cascade of Smiles
3001 Sollers Point Road
Baltimore MD 21222
(410)284-1414
dundalkdentistry.com
dundalkdentistry@verizon.net

Patient Name: ____________ ____________ ____ ____________

Last | First | MI | Preferred Name

Please list all medications you are currently taking:

Physician's name and phone number:

Have you been hospitalized since your last appointment? If yes, please describe:

Any joint replacements (hip, knee, other)? Please describe type and year:

Any Cancer? If yes, indicate type, treatment and date.

Please indicate if you have experienced any of the following:

- ☐ Allergic to Aspirin
- ☐ Allergic to Penicillin
- ☐ Allergic to Codeine
- ☐ Allergic to Latex
- ☐ Blood Thinners
- ☐ Heart Disease/ Surgery
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Emphysema/ COPD
- ☐ Diabetes
- ☐ Epilepsy/ Seizures
- ☐ Hepatitis
- ☐ Veneral Disease

Any other allergies: Please list:

Additional notes/details:

Do you smoke or chew tobacco? If yes, indicate how much

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Chart #. ____
FOR OFFICE USE ONLY

Patient Name: ____ Last ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc
Gender: ○ Male ○ Female
Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ____ Prev. Visit: ____ Email Address: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile
Best time to call: ____

Address: ____ ____
____ City ____ State ____ Zip Code

## Referred By

____

## Primary Dental Insurance

Name of Insured: ____ Last ____ First ____ MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____

## Secondary Dental Insurance

Name of Insured: ____ Last ____ First ____ MI

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____

Response Date: ____