Cascade of Smiles
3001 Sollers Point Road
Baltimore MD 21222

dundalkdentistry.com

(410)284-1414

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: _____