C.H. Martone, D.M.D. 1625 Union Avenue Natrona Heights, PA 15065

PATIENT INFORMATION

Name of Patient ________________________________

__ Single __ Married __ Divorced __ Widowed __ Separated

Home Address ________________________________

City ____________________ Zip ______________

Telephone ______________ / ________________
HOME BUSINESS

Patient's Birthdate ____________ / Age ____________

Social Security No. ______________________________

Referred by ______________________________________

Name of Patient's Dentist__________________________

Name of Patient's Physician________________________

Have you been under a physician's care during the past year?
Yes______ No______
If yes, reason__________________________________

____

Have you any allergies to medication?______________

If yes, specify__________________________________

____

____

Patient Employed By ______________________________

____

Address ____

Occupation ______________________________________

Spouse or Parent Employed by ______________________

____

Address ____

Occupation ______________________________________

If patient is a minor, who is legally responsible?____________

____

I hereby certify that the above information is true and correct
Patient's Signature______________________Date________

Are you presently taking any over the counter or prescription medication? If yes, please specify.

____

____

____

____

Height________ Weight_________

Have you ever had any of the following?

Rheumatic Fever	____ Yes	____ No
Heart Disease	____ Yes	____ No
Mitral Valve Prolapse	____ Yes	____ No
High Blood Pressure	____ Yes	____ No
Diabetes	____ Yes	____ No
Blood Disease	____ Yes	____ No
Prolonged Bleeding	____ Yes	____ No
Tuberculosis	____ Yes	____ No
Asthma	____ Yes	____ No
Bronchitis	____ Yes	____ No
Radiation Therapy	____ Yes	____ No
Chemotherapy	____ Yes	____ No
Kidney Disease	____ Yes	____ No
Hepatitis	____ Yes	____ No
Stomach Ulcers	____ Yes	____ No
Liver Disease	____ Yes	____ No
Major Operation	____ Yes	____ No

Specify________________________________

____

Convulsions	____ Yes	____ No
Porphyria	____ Yes	____ No
Glaucoma	____ Yes	____ No
Immuno-Suppression	____ Yes	____ No
Substance Abuse	____ Yes	____ No
Thyroid Disease	____ Yes	____ No

For Women

Are you taking birth control pills? __Yes __No
Are you pregnant? __Yes __No
If yes, week #__________________________

Date of last menstrual cycle__________________

Antibiotics may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

PERSON TO CONTACT IF NECESSARY
Name____________________Relation____________
Telephone(Home)___________(Business)__________