Park City Dental
1615 E. 61st Suite #400
Park City KS 67219

(316)260-6868
appointments@parkcitydds.com
www.parkcitydds.com

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

Date of last dental visit? Treatment you had completed?

Current Medical Conditions (circle all that apply): ADHD; Anemia; Anxiety; Arthritis; Asthma; Autism; Blood Disease; Cancer; Diabetes-Type I or Type II; Dizziness; Fainting; Epilepsy; Fibromyalgia; Head Injuries; Heart Disease; Hepatitis; High Blood Pressure; HIV/AIDS; Kidney Disease; Liver Disease; Mental Disorders; Nervous Disorders; Respiratory Problems; Seasonal Allergies; Sinus Problems; Sleep Apnea; STD's; Stroke; Ulcers;
Do you have any other medical conditions not previously recorded? Please explain:

If you are a NEW patient, have you had a Panoramic X-ray in the last 5 years?

○ Yes ○ No

Do you have a latex allergy (Yes/No)?

○ Yes ○ No

Do you agree with the HIPPA Privacy Practices and policies?

○ Yes ○ No

May we contact you at your work number if needed?

○ Yes ○ No

Have you been hospitalized in the last 2 years(Yes/No)? If yes, please explain:

Are you allergic to Penicillin or any other medications? Please list:

Are you taking any kind of blood thinning medications? Please list:

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Have you ever taken medication for osteoporosis or cancer treatment(Yes/No)? If yes, please explain:

Do you have any artificial heart valves or joint replacements(Yes/No)(Date of replacement)? If yes, please explain:

Are you currently pregnant? (If yes, please list due date)

Do you currently use Tobacco? Please specify:

Please list any medications you are currently taking, or provide a copy of a list:

Preferred Pharmacy name, address, and phone:

Emergency contact name and phone number:

Signature of patient, parent, or guardian (responsible party):

Signature: ______________________________ Date:

Relationship to Patient:

Response Date: