TriMark Dental Clinic, LLP

Patricia Lyons DDS Tonya Wason DDS Eric Popp DDS

Date _____/_____/_____ Birthdate _____ Age____

Patient's Full Name_____

Home Address_____ City_____ State_____ Zip_____

E-Mail Address _____ Are you? Single___ Married___ Divorced____ Widow_____

SS# _____-____-_____ Cell #_____ Best contact #_____Work Phone_____

Employer's Name_____ Address _____

Dental Insurance Co. _____ Address _____ Group#_____

Spouse's Name _____Birthdate_____ Spouse's SS# _____-_____-_____Spouse Cell#_____

Spouse's Employer _____Address _____

Spouse's Dental Ins. Co. _____ Address _____ Group#_____

Medical History

Physician's Name _____ Clinic _____ City _____

Are you in good health? _____ Yes _____ No Pharmacy _____

Do you take medication for anything? ___Yes ___No List medicines: _____

Are you allergic to any drugs? ____ Yes ___No If so, what? _____

Is there any health condition we should know about? ___ Yes ___ No and what _____ Last Dental Visit _____

Circle if you have ever had any of the following:

Allergies	Celiac's	Headaches	Lupus	
Alzheimer/Dementia	Colitis	Heart Disease	Mitral Valve Prolapse w/regurgitation	
Anemia	Congenital Heart Defect	Heart Attack/Stroke	MRSA	
Angina Pectoris	Crohn's Disease	Heart Murmur	Pace Maker	
Arthritis	Diabetes	Hepatitis ABC	Radiation Therapy/Chemo	
Artificial Heart Valve	Difficulty Breathing	High/Low Blood Pressure	Sinus Problems	Female: Are you pregnant ?
Artificial Joint/Bones	Drug Abuse	Jaw pain	Smoker/chew	yes or no
Asthma	Emphysema	Kidney Disease	Thyroid Problems	Breastfeeding
Bleeding problems	Epilepsy/Seizures	Liver Disease	Tuberculosis	
Cancer	Fainting Spells	Leukemia	Ulcers	Other _____

Dental History Circle one

Sensitive or painful teeth	Bleeding Gums	Swelling or lump in mouth
Pain in or near ears	Reaction to local anesthetic	Clenching or grinding teeth

Do you need to be Pre medicated? Yes or NO

Are you happy with appearance of your teeth? _____

Who referred you to our office? We'd like to thank them! _____

Signature_____ Date_____