Dr Phillip Katz
156 W. Columbus St.
Pickerington, Ohio 43147
(614) 837-4506 phone
(614) 837-0192 fax

Patient Name: ______________________________

Date: ______________________ **Birthdate:**______________________

Phone:______________________Cell:__________________________

Email: ____

Medical Information

Personal **Physician**: ____
Name Address Phone #

Yes	No	
☐	☐	1. Have you been hospitalized within the past two years? For what? ________________
☐	☐	2. Are you currently being treated by a physician? For what? ________________
☐	☐	3. Are you currently taking any medications or drugs? What? ________________
☐	☐	4. Have you ever received counseling for excessive alcohol and/or prescription drug use?
☐	☐	5. Are you allergic to any drugs? What? ________________
☐	☐	6. Are you allergic to any metals? What? ________________
☐	☐	7. Have you ever had a skin rash or other reaction to metal jewelry? To what? __________
☐	☐	8. Do you bleed excessively upon injury?
☐	☐	9. Are you Pregnant?
☐	☐	10. Have you ever been involved with dental/legal activity?

Circle any of the following conditions which you have had

a. Arthritis
b. Asthma
c. Cancer
d. Diabetes
e. Epilepsy
f. Glaucoma
g. Heart Murmur
h. Heart Problem
i. Hepatitis
j. High Blood Pressure
k. HIV
l. Jaundice
m. Kidney Problems
n. Low Blood Pressure
o. Nervous Breakdown or Psychiatric Therapy
p. Rheumatic Fever
q. Sexually Transmitted Disease
r. Stroke
s. Tuberculosis
t. Other Diseases

If you circled either “h” or “t”, please describe condition:

____
____
____
____
____

Person to be Contacted in an Emergency

____

Name Address Phone#

Dental Information

Yes	No	
☐	☐	1. Do you have any dental needs or concerns? What? ________________
☐	☐	2. Are you apprehensive about dental treatment? How apprehensive? ________
☐	☐	3. Would you like nitrous oxide (laughing gas) for relaxation during your care?
☐	☐	4. Have you had difficulty with dental "Novocain" anesthetic? What Happened? _______
☐	☐	5. Do you have TMJ pain? Please describe ________________
☐	☐	6. Do you smoke? Approximately how many per day? _______

Responsibility and Consent Statement

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his staff for diagnostic purposes or dental treatment. I also consent to having records taken, which may include study models, photographs, and x-rays.

Signature ________________________________ **Date** ____________

Patient (or Guardian)

Signature ________________________________ **Date** ____________

Attending Dentist