

Brent Rusnak, DDS, PC M. Walter Young, D.D.S.
2314 E. Parham Road
Richmond, VA 23228

Date: _____

PATIENT INFORMATION UPDATE

Patient Name: _____
Last First MI Preferred

Address: _____
Street City Zip Code

Circle appropriate: Minor Single Married Divorced Email address: _____

SS#: _____ Birth Date: _____ Gender: Male/Female

Phone: Home _____ Work _____ Ext. _____ Cell _____

Employer: _____ If student, name of school _____

If Minor, Parent or Guardian Name: _____

Parent or Guardian Employer: _____

Person to contact in case of an emergency: _____

PATIENT MEDICAL HISTORY

Physician: _____ Phone: _____ Date of last exam: _____

Do you have, or have you ever had any of the following?

<input type="checkbox"/> Anesthesia Allergy <input type="checkbox"/> Codeine Allergy <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Metal Allergy <input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> Allergies, Other _____ <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcohol Treatment <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Disease <input type="checkbox"/> Dizziness <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Treatment <input type="checkbox"/> Epilepsy <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Head Injuries <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervous Disorder <input type="checkbox"/> Pacemaker <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Skeletal Implants <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors <input type="checkbox"/> Venereal Disease <p align="center"><u>WOMEN ONLY</u></p> <input type="checkbox"/> Pregnancy Due date _____ Are you nursing? YES NO Taking Oral Contraceptives? YES NO
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• Have you been admitted to a hospital or undergone surgery during the past two years? Yes No
 If yes, please explain _____

• Are you under the care of a physician? Yes No Have you taken steroids in the last 2 years? Yes No

• Are you currently taking any medications? If yes, please list: _____

• Do you have any health problems that need further clarification? Yes No _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
 Signature of patient (or Parent/Guardian if minor)

 Date

WOULD A BEAUTIFUL SMILE MAKE YOU A MORE CONFIDENT PERSON?