Dr. Robert Cannis
1200 River Ave., Suite 3B
Lakewood, NJ 08701

Date _____ *Patient's Name* _____ *Date of Birth* _____

Address _____

Home Phone _____ *Work Phone* _____

Cell Phone _____ *E-mail* _____

Do you have dental insurance? _____ *Company* _____

Insured _____ *SS#* _____

DOB _____ *Employer* _____

Who referred you? _____

Medical Doctor _____ *Town* _____
Do you take medications? _____
_____
Do you take birth control pills? _____
Do you take vitamins or herbs? _____

Congenital Heart Disease
Heart Murmur
MVP
Pacemaker
Stomach Disease - Intestinal Disease
Abnormal Blood Pressure - Excessive Bleeding
Kidney Problems
Cancer Treatments - Chemo - Radiation
Arthritis
Head or Neck Injury

Diabetes
Heart Attack
Angina
Artificial Joints
Hepatitis
VD or AIDS
Lyme
Epilepsy
Convulsions - Stroke
Asthma

Do you smoke? _____
Have you ever had a major operation? _____
Allergic to medications? _____

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Have you ever been told to pre-medicate? _____
Are there any other health problems? _____

Dental History

Do you have any prior x-rays? _____

Any problems in previous dental offices? _____ *Allergic Reaction?* _____
Fainting? _____ *Bleeding?* _____ *Any Complications?* _____

Does food catch between your teeth? _____

Do you often have your teeth cleaned? _____

Do you have any sores or growths in your mouth? _____

Any dental complaints? _____

Do you have all your teeth? _____

Are your gums ever irritated? _____

Teeth sensitive to hot or cold? _____

Are you happy with their appearance? _____

Do you grind your teeth or clench? _____

Do you snore? _____