Heart Disease, Attack YES NO Kidney Trouble YES NO H.I.V Positive YES NO Heart Surgery YES NO Diabetes YES NO AI.D.S YES NO Chest Pain YES NO Diabetes YES NO Cold Sores/Fever Bilsters YES NO Chest Pain YES NO Thyroid Problems. YES NO Cold Sores/Fever Bilsters YES NO Congenital Heart Diseae YES NO Emphysema YES NO Blood Transfusion YES NO Congenital Heart Diseae YES NO Emphysema YES NO Dialysis YES NO Congestive Heart Failure YES NO Tuberculosis YES NO Dialysis YES NO Hemophilia YES NO Hegat Murmur YES NO Asthma YES NO Hemophilia YES NO High Blood Pressure YES NO Asthma YES NO Hemophilia YES NO High Blood Pressure YES NO Asthma YES NO Hemophilia YES NO High Blood Pressure YES NO Smoke Cigarettes YES NO Anemia YES NO Artificial Heart Valve Prolapse YES NO Chew Tobacco YES NO Sickle Cell Disease YES NO Artificial Heart Valve YES NO Hay Fever YES NO Bruise Easily YES NO Heart Pacemaker YES NO Allergies or Hives YES NO User Disease YES NO Rheart Pacemaker YES NO Allergies or Hives YES NO Hellow Jaundice YES NO Rhematic Fever YES NO Sinus Trouble YES NO Yellow Jaundice YES NO Arthritis/Rheumatism YES NO Tumors YES NO Epilepsy or Seizures YES NO Arthritis/Rheumatism YES NO Tumors YES NO Perioding or Dizzy Spells. YES NO Artificial Joint YES NO Radiation Therapy YES NO Nervousness/Anxiety YES NO Artificial Joint YES NO Rheatistic Pace YES NO Nervousness/Anxiety YES NO Amorexialbulimia YES NO Pepiclillin YES NO Tetracycline YES NO Nervousness/Anxiety YES NO Amorexialbulimia YES NO Amoxicillin YES NO Tetracycline YES NO No Vicodin/Norco YES NO Pepiclillin YES NO Tetracycline YES NO Usufa Drugs YES NO Amoxicillin YES NO Tetracycline YES NO Sulfa Drugs YES NO District YES NO Local Anesthetics YES NO Are you taking birth control pills? YES NO months Are you nursing? YES NO Other	Name								
Please list any drugs or medications that you are currently taking, their purpose and the physician who prescribed them Drug	Have you been a patient Have you been under the	in the e care	hospita	al during the past two years?	?		YES NO YES NO		
Drug	- " duna o		· · · · · · · · · · · · · · · · · · ·				and the abusinian who proces	-ihad	tham.
Atrial Fibrillation		' Meur	CATIONS .		Then p	Turpose .		TIDEG .	(1161111
Atrial Fibrillation									
Heart Disease, Attack YES NO Kidney Trouble YES NO H.I.V Positive YES NO Diabetes YES NO A.I.D.S. YES NO Cold Sores/Fever Blisters YES NO Congenital Heart Diseae YES NO Emphysema YES NO Diabysis YES NO Congenital Heart Diseae YES NO Emphysema YES NO Diabysis YES NO Heart Murmur YES NO Asthma YES NO Anemia YES NO Anemia YES NO Heart Murmur YES NO Smoke Cigarettes YES NO Anemia YES NO Anemia YES NO Heart Male Yes NO Congenital Heart Disease YES NO Congressive Heart Pale Yes NO Congressive YES NO Congressive Heart Pale Yes NO Congressive YES NO Heart Pacemaker. YES NO Hay Fever YES NO Liver Disease YES NO Heart Pacemaker YES NO Allergies or Hives YES NO Filepsy or Seizures. YES NO Congressive YES NO Filepsy or Seizures. YES NO Repliepsy or Seizures. YES NO Anthritis/Rheumatism YES NO Tumors YES NO Filepsy or Seizures. YES NO Anthritis/Rheumatism YES NO Tumors YES NO Filepsy or Seizures. YES NO Anthritis/Rheumatism YES NO Chemotherapy YES NO Anthritis/Congress/Anxiety. YES NO Anthritis/Congress/Anxiety YES NO Polyou have or have you had any disease, condition or problem not listed? If so, please list: **Do you have or have you had an allergy, unusual reaction or addiction to the following?** Aspirin	Indicate which of the fo	ollowi	ng you	have had or have at prese	ent. C				
Heart Surgery									NO
Chest Pain	•			•					NO
Congenital Heart Diseae YES NO Emphysema									NO
Congestive Heart Failure YES NO Tuberculosis YES NO Dialysis YES NO Heart Murmur YES NO Asthma YES NO Hemophilia YES NO High Blood Pressure. YES NO Smoke Cigarettes. YES NO Anemia YES NO Mitral Valve Prolapse YES NO Chew Tobacco YES NO Sickle Cell Disease YES NO Artificial Heart Valve YES NO Hay Fever YES NO Bruise Easily YES NO Artificial Heart Valve YES NO Allergies or Hives. YES NO Liver Disease YES NO Cortisone Medicine YES NO Allergies or Hives YES NO Liver Disease YES NO Cortisone Medicine YES NO Allergies or Hives YES NO Epilepsy or Seizures YES NO Allergies or Hives YES NO Epilepsy or Seizures YES NO Arthritis/Rheumatism YES NO Cancer YES NO Epilepsy or Seizures YES NO Arthritis/Rheumatism YES NO Tumors YES NO Fainting or Dizzy Spells YES NO Artificial Joint YES NO Radiation Therapy YES NO Nervousness/Anxiety YES NO Artificial Joint YES NO Radiation Therapy YES NO Anorexia/Bullmia YES NO Artificial Joint YES NO Chemotherapy YES NO Anorexia/Bullmia YES NO Psychiatric Care YES NO Pseloillim YES NO Tetracycline YES NO Codeine YES NO Codeine YES NO Amoxicillim YES NO Tetracycline YES NO Vicodin/Norco YES NO Amoxicillim YES NO Percocet YES NO Sulfa Drugs YES NO Are you taking birth control pills? YES NO months Are you nursing? YES NO Latex YES NO Are you pregnant? YES NO months Are you nursing? YES NO Patentifician to the best of my knowledge. Patient's (or Guardian's) Signature				•					NO
Heart Murmur YES NO Asthma. YES NO Hemophilia	_								NO
High Blood Pressure YES NO Smoke Cigarettes YES NO Anemia	•						•		NO
Mitral Valve Prolapse YES NO Chew Tobacco							· · · · · · · · · · · · · · · · · · ·		
Artificial Heart Valve	•								
Heart Pacemaker YES NO Allergies or Hives YES NO Liver Disease	·								
Cortisone Medicine				•			•		NO
Rheumatic Fever				9					-
Arthritis/Rheumatism YES NO Tumors									
Stroke									NO
Artificial Joint YES NO Chemotherapy									NO
(Knee,Hip, etc.) Hepatitis A, B or C YES NO Psychiatric Care YES NO Do you have or have you had any disease, condition or problem not listed? If so, please list: Do you have or have you had an allergy, unusual reaction or addiction to the following? Aspirin									NO
Do you have or have you had an allergy, unusual reaction or addiction to the following? Aspirin		1 20	INC						NO
Do you have or have you had an allergy, unusual reaction or addiction to the following? Aspirin		u had	any dis					1 600	110
Aspirin									
Penicillin									
Amoxicillin	•								NO
Ampicillin									NO
Cipro									
Are you taking birth control pills? YES NO Are you Pregnant?									NO
Are you taking birth control pills? YES NO Are you Pregnant?YES NOmonths Are you nursing?YES NO I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all que tions truthfully and to the best of my knowledge. Patient's (or Guardian's) Signature Date Doctor's Signature	Olpio	1	140	T William The Table 1	1	110		1 ===	110
Are you Pregnant?	Are you taking birth control	l pills?	YES	NO					
Patient's (or Guardian's) Signature Date					Are you	nursing?	? YES NO		
Patient's (or Guardian's) Signature Date	I understand that the above i	informa	ation is no	ecessary to provide me with den	tal care	in a safe	and efficient manner. I have answ	wered a	II ques
Doctor's Signature	• •								
							Date		
Comments/Updates:	Doctor's Signature				•				
	Comments/Updates:								

Welcome to the office of James D. Prigmore, DDS Patient's Name ____ Date of Birth ____ Address Social Security # _____ Zip code _____ City _ Insurance I.D. # _____ E-mail address ___ Home Phone Marital Status: S M D W Cell Phone _ Minor patient's parent or guardian Work Phone If patient is full time student, name of school _____ Emergency contact _____ Relationship ____ Address _____ Phone # ____ Whom may we thank for referring you to our office? — Insurance & Responsible Party Information —— Insured's Name __ __ Date of Birth _____ Relationship to Patient: Self Spouse Parent Step-parent Other ___ _____ *SS#* _____ Address ___ Home & Cell Phone _____ Employer ___ Work Phone _____ Insurance Company _____ Group # __ Ins. Co. Address _____ Ins. Co. Phone ___ Name of Union ____ _____ Local# _____ Union Phone _____ If you have dual insurance, please complete the following: Insured's Name ___ __ Date of Birth _____ Relationship to Patient: Self Spouse Parent Step-parent Other ___ _ *SS#* ____ Employer _ Phone __ Insurance company _____ Group # ___ Name of Union _____ Local# ____ ___ Union Phone _____ Dental Information -Do your gums bleed when you brush? YES NO Are your teeth sensitive to pressure? YES NO Do you have fear of dental work? YES NO Are your teeth sensitive to heat and cold? YES NO Do you grind or clench your teeth? Are you suffering from pain or swelling in YES NO YES NO Are your teeth sensitive to sweets? YES NO your mouth? If you could change your smile, what would you do? ___ Date of last dental exam and/or cleaning: _ ____ Name of previous dentist: _____ What was done at your last dental appointment? — Why did you leave your last dentist? —