Magnuson Dental

Free Dental Day Clinic Application

Personal

Name: ______________________________ Date: ______________________________

Date of Birth: ______________________________ Living Situation: ☐Rent ☐Own ☐Shelter ☐Transitional Housing ☐Street/Car

Phone Number: ________________ Address: ______________________________

City: ________________ State: ________________ Zip code: ________________

Email Address: ______________________________ Sex: ☐Male ☐Female

---

Emergency

Emergency Contact: ______________________________ Relationship: ______________________________

Phone Numbers: ______________________________

Job & Insurance

Job: ______________________________ Dental Insurance: ______________________________

Monthly Income: ________________ Family Size: ________________

☐ Proof of Income provided (Initials by Magnuson Dental __________)

Dental

Last Dental Visit: ______________________________ Practice: ______________________________

Current Dental Pain or Needs: ______________________________

____

____

Medical

Primary Care Provider: ______________________________ Group/Clinic: ______________________________

Last Seen: ______________________________

Medical History

Are you under existing care currently? ☐Yes ☐No, If yes, ______________________

Have you been hospitalized or had a major operation? ☐Yes ☐No, If yes, ______________________

Have you ever had a serious head or neck injury? ☐Yes ☐No, If yes, ______________________

Are you taking and medications, pills or drugs? ☐Yes ☐No, If yes, ______________________

Do you take, or have you taken, Phen-Phen or Redux? ☐Yes ☐No, If yes, ______________________

Have you ever taken Fosamax, Boniva, Actonel, or any other bisphosphonates? ☐Yes ☐No

If yes, ______________________

Are you on a special diet? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No

Do you use controlled substances? ☐Yes ☐No, If yes, ______________________

Women: Are you? ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ None

Allergies: ☐None ☐Penicillin ☐Latex ☐Sulfa Drugs ☐Acrylic ☐Aspirin ☐Metal ☐Local Anesthetics

☐ Other: ______________________

Do you have any of the following?

- ☐AIDS/HIV
- ☐Alzheimer's Disease
- ☐Anaphylaxis
- ☐Anemia
- ☐Angina
- ☐Arthritis/Gout
- ☐Artificial Heart Valve
- ☐Artificial Joint
- ☐Asthma
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Breathing problems
- ☐Bruise Easily
- ☐Cancer
- ☐Chemotherapy
- ☐Chest Pains
- ☐Cold Sores/Fever Blisters
- ☐Congenital Heart Disorder
- ☐Convulsions
- ☐Cortisone Medicine
- ☐Diabetes
- ☐Drug Addiction
- ☐Easily Winded
- ☐Emphysema
- ☐Epilepsy or Seizures
- ☐Excessive Bleeding
- ☐Excessive Thirst
- ☐Fainting Spells/Dizziness
- ☐Frequent Cough
- ☐Frequent Diarrhea
- ☐Frequent Headaches
- ☐Genital herpes
- ☐Glaucoma
- ☐Hay Fever
- ☐Heart Attack/Failure
- ☐Heart Murmur
- ☐Heart Pacemaker
- ☐Heart Trouble/Disease
- ☐Hemophilia
- ☐Hepatitis A
- ☐Hepatitis B or C
- ☐Herpes
- ☐High blood Pressure
- ☐High Cholesterol
- ☐Hives or Rash
- ☐Hypoglycemia
- ☐Irregular Heartbeat
- ☐Kidney Problems
- ☐Leukemia
- ☐Liver Disease
- ☐Low Blood Pressure
- ☐Lung Disease
- ☐Mitral Valve Prolapse
- ☐Osteoporosis
- ☐Pain in Jaw Joints
- ☐Parathyroid Disease
- ☐Psychiatric Care
- ☐Radiation Treatments
- ☐Recent Weight Loss
- ☐Renal Dialysis
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Scarlet Fever
- ☐Shingles
- ☐Sickle Cell Disease
- ☐Sinus Trouble
- ☐Spina Bifida
- ☐Stomach/Intestinal Disease
- ☐Stroke
- ☐Swelling of Limbs
- ☐Thyroid Disease
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Tumors and Growths
- ☐Ulcers
- ☐Venereal Disease
- ☐Yellow Jaundice

Have you ever had any serious illness not listed above? ______________________

Signature: ______________________ Date: ______________