EPICITI
MOBILE DENTAL CARE

FORM 2

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Screening Form

PATIENT	POWER OF ATTORNEY (if applicable)
First Last	First Last
Date of Birth: DD / MM / YYYY Contact no.	Contact no. Relationship: ☐ Son ☐ Daughter ☐ Other:
Residence	
Address	Billing Address
Room no. Sex: ☐ M ☐ F	City Prov./St. Postal/ZIP

MEDICAL/DENTAL HISTORY

Medical Doctor Name: _____ Date of last visit: _____

Are you currently being treated by your physician? ☐ No ☐ Yes

Describe: _____

Have you had any serious illness/operation? ☐ No ☐ Yes

Describe: _____

Have you ever been instructed to take antibiotics before a dental appointment? ☐ No ☐ Yes

Have you had any of the following?

- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Blood Disease
- ☐ Blood Pressure (High)
- ☐ Blood Pressure (Low)
- ☐ Cancer/ Type: _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Cough (Persistent)
- ☐ Diabetes/Kidney disease
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Heart Problems/Angina
- ☐ Hemophilia
- ☐ Hepatitis/Jaundice
- ☐ HIV Positive/AIDS
- ☐ Liver Disease
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Nervous Problems
- ☐ Prolonged Bleeding
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis/Lung
- ☐ Venereal Disease
- ☐ Problems Lying Back
- ☐ Other: _____

MEDICATIONS

List all current medication: _____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Other: _____
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold any member of the dental staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature (Patient/Power of Attorney): _____ Date: _____