NEAL W. ROGOL, DMD
FAMILY DENTIST

Neal W Rogol DMD, Inc.
24 Salt Pond Road, Unit G2
South Kingstown, RI 02879
401-214-0880

MEDICAL FORM

Patient Information

Patient Name:_____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor ☐ Other_____

Social Security #:_____ Birth Date:_____ E-Mail:_____

Phone (Home):_____ Mobile/Cell:_____ (Work):_____ Ext:_____

Address:_____
Street Apartment #

_____
City State Zip Code

In case of Emergency, contact: Name:_____ Phone :_____ Relationship_____

Health Information

Previous Dentist:_____ Date of Last Dental Visit:_____

Date of Last x-rays:_____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐AIDS	☐Dizziness/Fainting	☐Hives/Skin Rash	☐Respiratory Problems	☐Latex Allergy
☐Alcohol/Drug Addiction	☐Epilepsy/Seizures	☐Kidney Disease	☐Rheumatic Fever	☐Penicillin Allergy
☐Allergies	☐Excessive Bleeding	☐Liver Disease	☐Sinus Problems	☐Other Anesthetic Allergy
☐Anemia	☐Glaucoma	☐Lung Disease	☐Stomach Problems/Ulcers	
☐Arthritis/Rheumatism	☐Head Injuries	☐Mental Disorders	☐Stroke	OTHER:
☐Artificial Heart Valve	☐Heart Attack	☐Mitral Valve Prolapse (MVP)	☐Thyroid Disease	☐_____
☐Artificial Joints	☐Heart Defect	☐Nervous Disorders	☐Tobacco Usage	☐_____
☐Asthma	☐Heart Disease	☐Pacemaker	☐Tuberculosis	☐_____
☐Blood Disease	☐Heart Murmur	☐Pregnancy	☐Tumors/Growths	☐_____
☐Cancer	☐Hepatitis	Due:_____	☐Venereal Disease	
☐Chest Pain	☐High Blood Pressure	☐Prescribed Weight Loss Med	☐Antibiotics Allergy	
☐Diabetes	☐HIV Positive	☐Radiation Treatment	☐Codeine Allergy	

Have you ever had any complications following dental treatment? ☐Yes ☐No

If yes, please explain: _____

Do you experience dry mouth?_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician:_____ Phone:_____

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

If yes, please explain: _____

Are you taking any medications? ☐ Yes ☐ No
Please List: _____

What is your primary source of water? ☐ Well ☐ Town/County

Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor or hygienist at the next appointment without fail.

Patient (or Parent if minor child) Signature_____Date:_____

Who may we thank for this referral?_____