RINALDI
DENTAL ARTS
SMILE BEAUTIFICATION // ORAL RESTORATION // WHOLE BODY WELLNESS

5481 Wisconsin Ave, Suite 221
Chevy Chase, MD 20815
301-652-3355

HEALTH HISTORY

Name: _____ **Birthdate:** _____

Mailing Address: _____
(City) *(State)* *(Zip)*

Who may we thank for referring you to our office: _____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ **Email**: _____

Employer & Address: _____

Account Responsibility if someone other than yourself:

Name: _____ **Phone:** _____

Person to contact in case of an emergency:

Name: _____ **Phone:** _____

HEALTH HISTORY (please check if you have or had any of the following:)

☐ Yes ☐ No	AIDS, ARC, HIV Positive
☐ Yes ☐ No	Arthritis, Joint Pain or Stiffness
☐ Yes ☐ No	Artificial Joints/Implants
☐ Yes ☐ No	Asthma, Lung Disease, TB
☐ Yes ☐ No	Birth Control Pills
☐ Yes ☐ No	Bladder or Kidney Disease
☐ Yes ☐ No	Bleeding Problems, Bruise Easily
☐ Yes ☐ No	Cancer/Tumors
☐ Yes ☐ No	Chest Pain, Shortness of Breath
☐ Yes ☐ No	Cold Sores, Fever Blisters, Herpes
☐ Yes ☐ No	Cortisone Medicine
☐ Yes ☐ No	Depression
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Fainting or Seizures
☐ Yes ☐ No	Has your health changed in the last year?

If yes, please explain:
_____

☐ Yes ☐ No	Glaucoma
☐ Yes ☐ No	Headaches, Ringing in Ears
☐ Yes ☐ No	Heart Disease, Irregular Heartbeat, Murmurs, Prosthetic Heart Valve, Rheumatic Fever
☐ Yes ☐ No	Hepatitis or Liver Disease
☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Latex Allergies
☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	Pregnant: month_____
☐ Yes ☐ No	Radiation treatment
☐ Yes ☐ No	Recreational drugs/alcohol
☐ Yes ☐ No	Restless leg syndrome
☐ Yes ☐ No	Sinus Problems
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Thyroid Problems
☐ Yes ☐ No	Are you under the care of a physician?

If yes, please explain:
_____

Do you use tobacco? ☐ Yes ☐ No

Do you need to be pre-medicated? ☐ Yes ☐ No

List any and all **ALLERGIES:**_____

List any and all **DRUGS/MEDICATIONS** you are taking:_____

I certify that I have read and understand the above information to the best of my knowledge. Since Dr Rinaldi lectures, I authorize him to use my case and photographs for teaching or promotional purposes.

PATIENT SIGNATURE: _____ **DATE:** _____

DOCTOR SIGNATURE: _____ **DATE:** _____