TriMark Dental Clinic, LLP

Mark Karrels DDS   Patricia Lyons DDS   Tonya Wason DDS   Eric Popp DDS

Date _____/______/______ Birthdate _____________ Age____

Patient's Full Name____

Home Address____ City________________ State______ Zip________

E-Mail Address ______________________________ Are you? Single___ Married______

SS# ________-____-____________ Cell #_____________ Home phone_____________ Work Phone_____________

Employer's Name__________________________ Address ____

Dental Insurance Co. ____________________________ Address _____________________________ Group#________

Spouse's Name ______________________ Birthdate__________________ Spouse's SS# _______-_____-___________

Spouse's Employer ____________________________Address ____

Spouse's Dental Ins. Co. ______________________ Address ______________________________ Group#_________

Medical History

Physician's Name ____________________________ Clinic ____________________________ City _____________

Are you in good health? _____ Yes _____ No Pharmacy ______________________

Do you take medication for anything? ___Yes ___No List medicines: ____

Are you allergic to any drugs? ____ Yes ___No If so, what? ____

Is there any health condition we should know about? ___ Yes ___ No and what __________ Last Dental Visit _____________

Circle if you have ever had any of the following:

Anemia	Heart Murmur	Kidney Disease	Liver Disease	Smoker
Pace Maker	Thyroid Problems	Lupus	Jaw pain	Ulcers
MRSA	Artificial Heart valve	Crohn's Disease	Drug Abuse	Arthritis
Allergies	Colitis	Dementia	Emphysema	Cancer
Glaucoma	Congenital Heart Defect	Difficulty Breathing	Fainting Spells	Hepatitis ABC
Angina Pectoris	Diabetes	Asthma	Tuberculosis	Epilepsy/Seizures
Rheumatic Fever	Sinus Problems	Heart Disease	Bleeding Problems	Headaches
Radiation Therapy/Chemo	Heart Attack/Stroke	Artificial Joint/Bones	High/Low Blood Pressure	

MitralValve Prolapse w/regurgitation

Females: Are you Pregnant? Yes or No   Other_________________

Dental History Circle one

Sensitive or painful teeth	Bleeding Gums	Swelling or lump in mouth
Pain in or near ears	Reaction to local anesthetic	Clenching or grinding teeth

Are you happy with appearance of your teeth? ____

Who referred you to our office? We'd like to thank them! ____

Signature____ Date___________________________