123 N Chalkville Rd
Trussville, AL 35173
205-853-4600

MARSHALL FAMILY DENTISTRY

Dr. Reid Marshall
Dr. Elizabeth Anne Pickering

Contact Us:
mrmarshalldmd@gmail.com
marshallfamilydentistry.net

Patient Information

Name: ____________________ ____ ____________________________ ____________________________
First MI Last Preferred Name

DOB: __________ SSN: ____________________ Gender: Male/Female Status: Married/Single/Child/Other
*At least last four digits Please Circle One Please Circle One

Email Address: ____ Best time to call: ____________________________

Phone: ______________________________ ______________________________ ______________________________
Home Mobile Work/Other

Address: ____

______________________________ ____________ ________________
City State ZIP Code

Responsible Party Information – If the patient is the responsible party, you may leave this section blank. If the responsible party is someone other than the patient, please list name, DOB, SSN, phone number, address, and email address.

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Employer Name: ____ Phone Number: ___________________________

Address: ____ __________________ ______ ________________
City State ZIP Code

Emergency contact and parent/guardian name and phone number: ____

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How did you hear of our office? Another patient, insurance list, internet, etc.? ________________________________

Are you having any present dental complaints? Is there anything about your smile you would like to change, such as whitening, spacing, or wearing? ____

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Are you interested in having nitrous oxide ("Happy Gas") with your dental treatment at any point? YES / NO

When was your last dental cleaning? Do you have current x-rays at another office? ____________________________

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Medical History

Do you or have you ever taken Prolia, Zometa, Aredia, Boniva, Reclast, Fosamax or any other bone building (bisphosphorate drugs) by IV, injection or by mouth? YES / NO

Please list any medications you are taking: ______________________________

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Are you required by your physician to take antibiotics, pre-medication before dental appointments? YES / NO

Do you smoke or use smokeless tobacco? YES / NO

Ladies: Are you pregnant, or do you think you may be pregnant? If yes, when is your due date?

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Do you have or have you ever had any of the following?

O Acid Reflux	O Allergies – Other Meds	O Allergy – Aspirin	O Allergy – Codeine
O Allergy – Epinephrine	O Allergy – Hydrocodone	O Allergy – Keflex	O Allergy – Latex
O Allergy – Metals	O Allergy – Penicillin	O Alzheimer's/Dementia	O Anemia
O Arthritis	O Asthma	O Blood Disease	O Blood Thinners
O Cancer	O Chemotherapy Tx	O Chest Pain/Angina	O Diabetes Type 1
O Diabetes Type 2	O Drug/Alcohol Rehab	O Epilepsy/Seizures	O Excessive Bleeding
O Fainting/Dizziness	O Fever Blisters	O Gum Treatment	O Head Injuries
O Heart Attack	O Heart Condition	O Heart Disease	O Heart Murmur
O Hepatitis A	O Hepatitis B	O Hepatitis C	O High Blood Pressure
O HIV/Aids	O Joint Replacement	O Kidney Disease	O Liver Disease
O Low Blood Pressure	O Lupus	O Mental Disorders	O Mitral Valve Prolapse
O MS/CP	O Organ Transplant	O Pacemaker/Defib	O Pain Management Tx
O Pregnancy (now)	O Radiation Treatment	O Respiratory Problems	O Sinus/Hay Fever
O STD's	O Stents	O Stomach Problems	O Stroke
O Thyroid	O TMJ Problems	O Tuberculosis	

If you have any other health issues not already discussed, please list. ______________________________

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