# WELCOME!

## The Worcester Dentist Group, Dr. Ammar Bash DMD

Patient Information:

_____

Name: _____ Date Of Birth: _____

Address:_____City:_____State:_____ Zip Code: _____

Home Phone:_____ Cell Phone: _____

Email Address:_____ Responsible Party (If Applicable):_____

**Medical History:**

_____

Do you have or have you had any of the following? Please indicate with a check mark.

| | | | |
|---|---|---|---|
| ___Heart Problems | ___Allergies to Anesthetics | ___Malignancies | ____Typhoid Fever |
| ___High Blood Pressure | ___Allergies to medications/drugs | ____Measles | ____Tonsillitis |
| ___Low Blood Pressure | ___Allergies to_____ | ____Mumps | ____ Tuberculosis |
| ___Circulatory Problems | ___Anemia | ____Psychiatric Care | ____ Ulcer |
| ___Nervous Problems | ___Arthritis | ____Rheumatic Fever | ____Venereal Disease |
| ___Radiation Treatments | ___Asthma | ____Scarlet Fever | |
| ___Excessive Bleeding | ___ Diabetes | ____Prev. History of Endocarditic | |
| ___Aids | ___Hepatitis | ____Sinus Problems | |
| ___Atrial Fibrillation | ___Herpes | ____Stroke | |
| ___Joint Replacement (knee, hip, etc.) | | ____Any blood thinners(Aspirin, Plavix, Coumadin) | |

Are you currently pregnant? ___YES ___NO

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL/DENTAL INFORMATION THAT MAY AFFECT YOUR DENTAL TREATMENT:

_____

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS:

_____

_____

_____

How did you hear about us?_____

Patient Signature:_____Date:_____

Parent: Guardian Signature:_____Date:_____

Doctor Signature:_____Date:_____