Welcome to Vitality!

Kamala Lewis, DDS ND

508 E. Pierce St.

Luling, TX 78648

PATIENT INFORMATION

DATE_____

PATIENT NAME _____

MAILING ADDRESS_____

_____

CITY STATE ZIP

SEX M F AGE _____ BIRTHDATE_____

SINGLE MARRIED WIDOWED SEPERATED DIVORCED

ANNIVERSARY DATE _____

OCCUPATION_____

EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

Medications

List all medications you are <u>currently</u> taking:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Please circle if you are allergic to or had a reaction to any of the following:

Local anesthetics like Novocain

Penicillin or other antibiotics

Sedatives or sleeping pills

Aspirin

Iodine

Latex

Metal

Any other thing? _____

Have you had any serious illness or operation? Yes No If yes, describe _____

Have you ever had a serious head or neck injury? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, approximate date _____

Are you on a special diet? Yes No Do you use tobacco? Yes No

Do you use controlled substances? Yes No

(Women) Are you pregnant? Yes No Date Due _____ Doctor's Name _____

Nursing? Yes No Taking birth control pills? Yes No Doctor's Phone # _____

Agreement to Receive Electronic Communication

E-Mail Address: _____ Mobile # _____

(Initial below)

I _____ DO AGREE

I _____ DO NOT AGREE

That the office of Dr. Kamala Lewis Vitality may communicate with me electronically at the email address and/or mobile phone number I have listed above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the holistic practice any updates to my email address and/or mobile phone number.

My most preferred methods of electronic communication is:

(Initial below)

_____ Text Messaging

_____ Email

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient or Guardian Date