Dental Office Allergy Screening

Patient Name

Date of Birth

Date of Screening

Known Allergies (Select all that apply):

- [ ] Latex
- [ ] Penicillin
- [ ] Local Anesthetics
- [ ] Metals
- [ ] Acrylic
- [ ] Foods
- [ ] Other
- [ ] No Known Allergies

If other, please specify

Describe allergic reactions or symptoms

Notes/Additional Information

Screened By (Name/Title)