

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Email Address: _____ Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext. _____ Best time to call: _____

Preferred appointment times: Morning Evening Any Time M T W T

Address: _____
Street Apartment #
City State Zip Code

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pregnancy Due Date: _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lip Lesions	<input type="checkbox"/> Tumors
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Fainting	<input type="checkbox"/> Migraines	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Growths	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> OTHER: _____

● Please list any medications you are currently taking: _____

● Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

● Do you need to pre-medicate 1 hour before dental treatment? Yes No
If yes, please explain: _____

● Have you been hospitalized or needed emergency care during the past 2 years? Yes No
If yes, please explain: _____

● Are you now under the care of a physician? Yes No
If yes, please explain: _____

● Name of Physician: _____ Phone: _____

● Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____