

### Patient Information

Patient Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_ Gender: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI

Birth Date: \_\_\_\_\_ Family Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

Email Address: \_\_\_\_\_

**Whom may we thank for referring you to our practice?** \_\_\_\_\_

### Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check YES or NO:**

<b>Y N</b>	<b>Y N</b>	<b>Y N</b>	<b>Y N</b>
<input type="checkbox"/> <input type="checkbox"/> AIDS	<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/> Sinus Problems
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Stomach Problems
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Fever Blisters	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Swelling of Feet / Ankles or Hands
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints/Hips	<input type="checkbox"/> <input type="checkbox"/> Frequent Cough	<input type="checkbox"/> <input type="checkbox"/> Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Growths	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Tumors
<input type="checkbox"/> <input type="checkbox"/> Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Have you ever taken Phen-Phen/Redux?	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> <input type="checkbox"/> Head Injuries	<input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> <input type="checkbox"/> X-ray of Cobalt Treatment
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> <b>Pregnancy</b> Due date: _____	<input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Radiation	<input type="checkbox"/> <input type="checkbox"/> Heart Lesion	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Allergy: Penicillin
<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> <input type="checkbox"/> Allergy: Latex
<input type="checkbox"/> <input type="checkbox"/> Cold Sores	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> <input type="checkbox"/> Allergy: Sulfa Drugs
<input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> <input type="checkbox"/> Allergy: Ibuprofen
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Allergy: Tetracycline
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A / B	<input type="checkbox"/> <input type="checkbox"/> Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Allergy: Aspirin
<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Allergy: Codeine
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Allergy: Epinephrine
<input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> <input type="checkbox"/> Allergies: _____

**Note to Women:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- Have you ever had any complications following dental treatment?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two 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: \_\_\_\_\_

**In case of emergency, whom shall we call: Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Phone Numbers:** \_\_\_\_\_

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, or if my medicines change, I will inform the doctors at the next appointment without fail.

**X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient, parent or guardian

**Reviewed by Dr:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Reviewed by Dr:** \_\_\_\_\_ **Date:** \_\_\_\_\_