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:

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