

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Email: _____ Gender _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> An Immunity Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | List all Medicine you |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | are taking : |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Severe Headaches | |
| <input type="checkbox"/> Dental Phobic | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Drug Allergies | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Latex Allergies | | |

- 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: _____

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

Date: _____

Signature of patient, parent or guardian _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____