Patient Information

Patient name: ____
Last, First MI

Birth Date: ______________ Male□ Female□ Single□ Married□ Widowed□ Child□ Student□ F/T□ P/T□

Social Security #: _________________________ Driver's License #: ________________________________

Phone #: ____________________ Work #: ______________________ Cell #: _______________________

Address: ____
Street Apt. #

____
City State Zip code

Email address to confirm appointments: ______________________________

In case of emergency contact: ____
Name Phone# Relationship

Health Information

Date of last dental visit: ________ Reason for today's visit: _________________________________

Please check yes or no if you have or ever had the following:

Condition		Condition		Condition	
Acid Reflux	Yes□ No□	Premedicate with antibiotics before dental work:	Yes□ No□	Heart attack	Yes□ No□
Anemia	Yes□ No□	Heart Murmur	Yes□ No□	Respiratory problems	Yes□ No□
Angina	Yes□ No□	Hepatitis A, B, or C	Yes□ No□	Rheumatic fever	Yes□ No□
Artificial valve/stent	Yes□ No□	High blood pressure	Yes□ No□	Scarlet fever	Yes□ No□
Artificial joints	Yes□ No□	HIV/AIDS	Yes□ No□	Sinus problems	Yes□ No□
Asthma	Yes□ No□	Kidney disease	Yes□ No□	Substance abuse	Yes□ No□
Aspirin a day	Yes□ No□	Liver disease	Yes□ No□	Stroke	Yes□ No□
Blood disease	Yes□ No□	Low blood pressure	Yes□ No□	Ulcers	Yes□ No□
Blood thinners (coumidin/warfarin)	Yes□ No□	Hearing impaired	Yes□ No□	TMJ pain	Yes□ No□
Cancer	Yes□ No□	Mitral valve prolapse	Yes□ No□	Thyroid disease	Yes□ No□
Chemo/Radiation	Yes□ No□	Nervous disorder	Yes□ No□	Tobacco use	Yes□ No□
Cong. Heart Failure	Yes□ No□	Organ transplant	Yes□ No□	Tuberculosis	Yes□ No□
Diabetes	Yes□ No□	Pacemaker	Yes□ No□	Taking birth control:	Yes□ No□
Dizziness/fainting	Yes□ No□	Epilepsy	Yes□ No□	Allergy Latex	Yes□ No□
Fosamax, Atonal, or Boniva	Yes□ No□	Pregnant currently with due date:_______	Yes□ No□	Allergy Penicillin explain:______________________	Yes□ No□
				Allergy to other medications: explain:______________________	Yes□ No□

Currently taking any prescribed medications? Yes □ No □
List:____
____

Are you under the care of a physician now or within the past three years? Yes □ No □
Explain: ________________________________Name of physician: ________________ City: ______________

Please list any further health problems that needs further clarification:________________________________

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.

Signature of patient or guardian X ________________________________ **Date:** ____________

Signature of doctor X ____ **Date:** ____________