



Patient Information

Patient Name: _____ Date: _____

Male ___ Female ___ Married ___ Single ___ Child ___ Other ___

Social Security Number: _____ Birth Date: _____

Phone (Home): _____ (Cell Phone): _____

Email: _____ Best Time To Call: _____

Address: _____

Emergency Contact (Name, Phone Number): _____

Date of Last Dental Visit: _____ Reason For Today's Visit: _____

Have You Ever Had Any Of The Following? Please Check All That Apply:

<input type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/>	Diet (Restricted)	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	List:	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>		<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	Codeine Allergy
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Penicillin Allergy
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Other Medication Allergy:
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Due Date:	<input type="checkbox"/>	
<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	Medications Being Taken:
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	
<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	
<input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	
<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	
<input type="checkbox"/>	Cortisone Medication	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	

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 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: _____ Date: _____

How did you hear about our practice?

___ Patient/Friend ___ Patient/Relative ___ Dental Office ___ Online ___ Other: _____