Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Preferred appointment times: ☐ Morning ☐ Afternoon Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Person _____ Phone _____

Health Information

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

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

☐ AIDS / HIV	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Allergies	☐ Dizziness	☐ Liver Disease	☐ Thyroid Problems
☐ Aspirin Allergy	☐ Epilepsy	☐ Mental Disorders	☐ Tuberculosis
☐ Codeine Allergy	☐ Excessive Bleeding	☐ Nervous Disorders	☐ Tumors
☐ Latex Allergy	☐ Fainting	☐ Pacemaker	☐ Ulcers
☐ Penicillin Allergy	☐ Glaucoma	☐ Pregnancy Now	☐ Venereal Disease
☐ Sulfa Allergy	☐ Growths	Due date: _____	OTHER:
☐ Anemia	☐ Hay Fever	☐ Radiation Treatment	☐ _____
☐ Arthritis	☐ Head Injuries	☐ Respiratory Problems	
☐ Artificial Joints	☐ Heart Disease	☐ Rheumatic Fever	☐ _____
☐ Asthma	☐ Heart Murmur	☐ Rheumatism	
☐ Blood Disease	☐ Hepatitis	☐ Sinus Problems	☐ _____
☐ Blood Thinner	☐ High Blood Pressure	☐ Stints	
☐ Cancer	☐ Jaundice	☐ Stomach Problems	

- **Medications** being taken now _____
- 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 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.

_____ 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: _____