

Patient Information

Patient Name: _____
Last Name First Name MI Preferred Name
Email Address: _____ May we contact you by e-mail? Y N
Social Security #: _____ Birthdate: _____ Gender: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____
Address: _____
Street City State Zip

Health Information

Date of last dental visit: _____ Reason for visit: _____

Have you ever had or currently have any of the following? Please check all that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anesthetic Allergy | <input type="checkbox"/> Chron's | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> COPD | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Taking Coumadin | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use?
Type & Amount/day: |
| <input type="checkbox"/> Ibuprofen Allergy | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Taking Plavix | |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pregnancy
Due Date: | <input type="checkbox"/> Recreational Drug Use?
Type(s) and Most Recent
Dates of Use: |
| <input type="checkbox"/> Shellfish Allergy | <input type="checkbox"/> GERD | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Other Allergies (list): | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other Health History: |
| | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Seizure Disorder | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Taking Bisphosphates | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disorder - hypo | |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disorder - hyper | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ/TMD | |
| | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Mental Health Issues | | |

LIST ALL
MEDICATIONS:

- Y N - Have you ever had any complications following dental treatment? If yes, please describe:
- Y N - Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please describe:
- Y N - Have you been under the care of a physician for a medical condition (within the past year)? If yes, please describe:
Name of Physician: _____
- Y N - Do you have any health problems that need further clarification? If yes, please describe:

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 Dr. Yarbro at my next appointment without fail.

Signature of patient or legal guardian

Date

Referral Information

How did you hear about our office and/or whom may we thank?

Notes (Office Use Only):