Patient Information

Date Printed:

Patient Name: _____
Last Name First Name MI Preferred Name

Email Address: _____ Best way to reach you? ☐ Phone ☐ Email ☐ Text

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:

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

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. I also verify that all information pre-printed on this form is correct.

_____
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):