Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

E-Mail Address___________________________________ May we contact you by E-Mail? ☐ Yes ☐ No

Social Security #: ________________________________ Birth Date: ______________________________

Phone (Home): ______________ (Work): _______________ Ext: ________ Cell Phone ________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: _________________ Reason for this visit: ___________________________________

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

- ☐ Allergy to Anesthetic
- ☐ Allergies ___________ ___________
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Coumadin
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Taking Plavix
- ☐ Currently Pregnant Due date:__________
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER:
- ☐ __________________ __________________
- ☐ __________________ __________________
- ☐ __________________

• **List all current medications:** ____
____

• 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

How did you hear about our office, whom may we thank?____

NOTES: