Patient Information

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

Gender: _____ Married/Single/Child: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Mobile): _____Work):_____Ext:_____

Address: _____
Street Apartment #

_____

E-Mail Address:_____

Emergency Contact name & phone # _____
City State Zip Code

Health Information

Reason for today's visit: _____ Preferred Pharmacy & Phone Number _____

Do you have a preferred Dentist? Y / N. If yes, whom: _____

***Do you require antibiotic premed prior to dental treatment*? Yes or No If yes, for what:_____**

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

- ☐ AIDS/HIV
- ☐ A fibrillation
- ☐ Alcohol/Drug Abuse
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Anxiety, Depression
- ☐ Arthritis
- ☐ Artificial Joints: _____
- ☐ Asthma
- ☐ Blood Clots/Embolism
- ☐ Blood Disease
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Congestive Heart Failure
- ☐ Diabetes A1C_____
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnant Currently Due date:_____
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Medication Allergies:

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy
- ☐ Other:_____
- ☐ **Current Medication**:

_____
_____
_____
_____
_____
_____

- ☐ **Other Conditions**:

_____
_____

Preferred Pharmacy

_____

Ph#_____

- Are you currently taking any ***medications for treatment of osteoporosis (oral or injection)***? ☐ Yes ☐ No
- Are you currently taking ***Blood Thinners***? ☐ Yes ☐ No
- 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: _____

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? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____