Patient Information

Date ______________________ E-Mail Address ____________________

Name: ____ Social Security #____________________

Last First Middle Initial

☐ Married ☐ Single ☐ Widowed ☐ Other Birth Date: __-__-____ Age: ___________

Address: ______________________________________ State: ____________ Zip: __________

Home Phone: _______________ (Work): _______________ Ext: _____ Cell # _________________

Whom may we thank for referring you?

Health Information

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

Please check those that apply:

- ☐ Allergies (seasonal)
- ☐ Fever Blisters/Oral Herpes
- ☐ Head Injuries
- ☐ Glaucoma
- ☐ Sinus Issues
- ☐ Thyroid Disorder
- ☐ TMJ Disorder
- ☐ Asthma
- ☐ Difficult Breathing/COPD
- ☐ Tuberculosis
- ☐ Smoker/Tobacco user
- ☐ Other Respiratory Issues
- ☐ HIV/AIDS/Venereal Ds.
- ☐ Diabetes
- ☐ Kidney or Liver Disease
- ☐ Stomach Disease/Ulcers
- ☐ Intestinal Disease/IBS
- ☐ Current Pregnancy
  Due Date: __________
- ☐ Arthritis or Rheumatism

- ☐ Artificial Joints
- ☐ Osteoporosis
- ☐ Bisphosphonate Therapy
  (Reclast, Boniva, Fosamax)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Blood Disease
- ☐ Coumadin or Other Blood Thinner
- ☐ Excessive Bleeding
- ☐ Coronary Stent Placement
- ☐ Heart Murmur
- ☐ Heart Attack/MI
- ☐ High Blood Pressure
- ☐ Bacterial Endocarditis
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Other Heart Disease
- ☐ Dizziness/Fainting

- ☐ Epilepsy
- ☐ Psychiatric Disorders
- ☐ Nervous Disorders
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Sleep Disorders
- ☐ Other Neurologic Issues
- ☐ Alcohol or Drug Use
- ☐ Cancer/Tumors
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Other____________

Allergies to:

- ☐ Penicillin
- ☐ Tetracycline
- ☐ Erythromycin
- ☐ Dental Anesthetics
- ☐ Aspirin
- ☐ Latex
- ☐ Codeine/Narcotic
- ☐ Sulfa Drugs
- ☐ Keflex

OTHER:

____

____

Please list any serious medical condition(s) and/or surgeries that you have experienced:

____

____

Are you taking any prescription and/or over the counter drugs? Yes/No If yes, please list each one and dose:

____

____

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:____________________

Name of Pharmacy: ______________________________________ 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