Patient Information

Patient Name: ____ **Date:** __________
Last First MI (Preferred Name)

Gender: Male Female **Family Status:** Married Single Child Divorced Widowed

Date of Birth:_______________________ **Social Security #:** _________________________

Phone #'s Home: _______________ Cell: __________________ Work: ____________________

Address: Street ____________________________________ Apt # _______________

City ____________________ State __________ Zip Code _________________

Email: ____

Emergency Contact: Name: ___________________________ Phone: ____________________

Health Information

Date of Last Dental Visit: ___________ **Reason for this Visit:** ____________________________

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

Dental Anesth. Allergy	Bisphosphonate/Fosamax	Low Blood Pressure	Stroke
Latex Allergy	Diabetes: Type_______	Kidney Disease	Tuberculosis
Metal Allergy	Cancer: Type________	Liver Disease	Tumors
Sulfa Allergy	Blood Disorder: ______	Difficulty Breathing	Ulcers
Penicillin Allergy	Anemia	Emphysema	Herpes/Fever Blisters
Erythromycin Allergy	HIV	Respiratory Problems	Alcohol/Drug Abuse
Codeine Allergy	Epilepsy	Arthritis	Asthma
Aspirin	Eating Disorder	Jaundice	Mental Disorder
Allergies____________	Head Injuries	Radiation Treatment	Nervous Disorder
Artificial Joints/Valves	Congenital Heart Def	Glaucoma	Fainting
Mitral Valve Prolapse	Heart Disease	Seizures	Hepatitis: **A B C**
Rheumatic Fever	Heart Murmur	Thyroid Problems	Phen-Fen
Coumadin	Pacemaker	Sinus Problems	
Stomach Problems	High Blood Pressure	Other ____________	

Please list any medications you are currently taking ____

____

Have you ever been admitted to a hospital or needed emergency care during the past two years? **YES NO**

If YES, please explain; ____

Are you 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; ____

WOMEN: Any prescribed method of birth control? **YES NO** Are you pregnant? **YES NO** Are you currently nursing? **YES NO**

Dental History

Are you currently in pain? **YES NO** Do your gums bleed? **YES NO** Would you like whiter teeth? **YES NO**

Do you like your smiles? **YES NO** Any discomfort in jaw joint/ TMJ? **YES NO** Do you use any form of tobacco? **YES NO**

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 doctor at the next appointment without fail.

Signature ____ Date ________________

Referral Information

Whom may we thank for referring you to our practice? ____________________________________