



Patient Information

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Gender: M F Family Status: _____ Birth Date: _____ SSN: _____

Phone (Home): _____ Phone (Work): _____ Ext: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____

Health Information

E-Mail: _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due Date: _____ | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | OTHER: _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | _____ |

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

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 now under the care of a physician? Yes No

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 changes in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other: _____

Name of person referring you to our practice: _____