Patient Information

Patient Name: _____ Date:_____
Last First MI

Address:_____
Street Apartment #

_____
City State Zip Code

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

Email: _____ Employer: _____

Social Security #: _____ Birth Date: _____ ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Other Date of Last Dental Visit: _____

Health Information

Do you have, or have you ever had, any of the following? Please check those that apply:

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma/Hay Fever
☐ Autoimmune Disease
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness/Fainting
☐ Epilepsy
☐ Excessive Bleeding
☐ Head Injuries
☐ Heart Disease
☐ HIV Infection
☐ Mitral Valve Prolapse
☐ Heart Valve Replacement
☐ Hepatitis/Jaundice
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems/ Ulcers
☐ Stroke
☐ Thyroid Problem
☐ Tuberculosis
☐ Tumors
☐ STD/HPV

ALLERGIES
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
☐ Aspirin_____
☐ Other_____

If are you pregnant:
Due date: _____

- Have you ever been required to take an antibiotic prior to a dental visit: ☐ Yes ☐ No
  If yes, please check why: ☐ Joint Replacement ☐ Heart Murmur ☐ Other: _____
- Please list all medication you are taking at this time: _____
  PLEASE INFORM US IF YOU ARE TAKING **BISPHOSPHONATES OR BLOOD THINNERS**.
- 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:_____

Note: Both Doctor and patient are encourage to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
If I have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Whom may we thank for referring you to our office? _____