PATIENT INFORMATION

Patient Name: _____ **Date:** _____/_____/_____
First MI Last

Gender: M / F **Married:** Yes / No **Date of Birth:** _____/_____/_____ **SSN:** _____

Patient Address: _____ **City, State, Zip:** _____

Home Tel: ( ) _____-_____ **Work:** ( ) _____-_____ext _____ **Cell:** ( ) _____-_____

Email Address: _____ **Referred by:** _____

Physician – Name & Phone Number: _____ **Pharmacy Phone Number**:_____

Emergency Contact – Name & Phone Number : _____

Dental Insurance Carrier: _____ **Employer:** _____

HEALTH INFORMATION

If you have or ever had any of the following diseases, please check Yes or No the listed below.

☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Adverse effects from dental treatment
☐ Yes ☐ No Cardiovascular Disease: CIRCLE ONE
Heart Murmur, Stroke, Pace Maker, Angina, Coronary Artery Disease, Heart Attack, Heart Trouble, Palpitations, Mitral Valve Prolapse
☐ Yes ☐ No Lung Disease: CIRCLE ONE
Asthma, Emphysema, Bronchitis, Pneumonia, Tuberculosis, Chest Pain, Chronic Coughing
☐ Yes ☐ No CIRCLE ONE
Seizures, Convulsions, Epilepsy, Fainting; Dizziness, or Panic Disorder
☐ Yes ☐ No Bleeding Disorder, Anemia, Blood Transfusion
☐ Yes ☐ No Liver Disease : Jaundice, Hepatitis
☐ Yes ☐ No Artificial Joints / Implants
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Thyroid Disease (Goiter)
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Stomach Ulcers / Colitis
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Radiation Treatments for Cancer

☐ Yes ☐ No Sinus / Nasal Problems
☐ Yes ☐ No Clicking or Popping of Jaw Joint
☐ Yes ☐ No HIV / Hepatitis / Sexual Transmitted Diseases
☐ Yes ☐ No Recurrent infections of any kind
☐ Yes ☐ No Tumors
☐ Yes ☐ No Any reason for depressed immune system
☐ Yes ☐ No Nervous Disorder
☐ Yes ☐ No Mental Disorder
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Other: _____
☐ Yes ☐ No Do you smoke or chew tobacco?
☐ Yes ☐ No Do you use alcohol?
☐ Yes ☐ No Are you using a controlled substance?
☐ Yes ☐ No Have you had any serious illnesses, operations, or hospitalizations?
Please describe: _____

FOR WOMEN ONLY

☐ Yes ☐ No Are you pregnant?
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No Are you using oral contraceptives?

☐ Yes ☐ No Are you using or taking any medications (including over the counter) medication?
If yes, please list: _____
☐ Yes ☐ No Are you allergic or have had a bad reaction to any medications?
If yes, please list: _____

Are you under a Physician's care for a particular reason? Y / N Date of last physical exam? _____

Please list any conditions or problems not listed above that you would like to speak with the doctor about: _____

_____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Patient /Guardian Signature: _____ Date _____