

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Birth Date: \_\_\_\_\_  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_  Male  Female E-mail: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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

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

Please list medications both prescription and over the counter:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• 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

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change to my health, I will inform the doctors at the next appointment without fail.

Signature of patient or guardian \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date: \_\_\_\_\_