

Patient Information

Patient Name: _____ Date: _____
Last, First, MI (preferred name)

Social Security #: _____ Gender: _____ Family Status: _____
Birth Date: _____

Phone (home): _____ (work): _____ Ext: _____ (Cell): _____

What is the best phone # and time to call? _____

Address: _____
Street Apartment #

City State Zip code
Preferred appointment times: Morning Afternoon Evening Any Time Mon Tue Wed Thur

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Please Circle "YES" or "NO" if you have ever had any of the following:

AIDS	YES NO	Fainting	YES NO	Mental Disorders	YES NO	Tumors	YES NO
Anemia	YES NO	Fen-Phen Diet	YES NO	Nervous Disorders	YES NO	Ulcers	YES NO
Arthritis	YES NO	Glaucoma	YES NO	Pacemaker	YES NO	Venereal Disease	YES NO
Artificial Joints	YES NO	Hay Fever	YES NO	Pregnancy	YES NO	ALLERGIES TO:	
Asthma	YES NO	Head Injuries	YES NO	DUE DATE: _____		Codeine	YES NO
Blood Disease	YES NO	Heart Disease	YES NO	Radiation Treatment	YES NO	Latex	YES NO
Cancer	YES NO	Heart Murmur	YES NO	Respiratory Problems	YES NO	Local Anesthetic	YES NO
Chemical Dependency	YES NO	Hepatitis	YES NO	Rheumatic Fever	YES NO	Penicillin	YES NO
Diabetes	YES NO	High Blood Pressure	YES NO	Rheumatism	YES NO	Sulfa	YES NO
Dizziness	YES NO	Jaundice	YES NO	Sinus Problems	YES NO	Other _____	
Epilepsy	YES NO	Kidney Disease	YES NO	Stroke	YES NO	_____	
Excessive Bleeding	YES NO	Liver Disease	YES NO	Tuberculosis	YES NO	_____	

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: _____

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 doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Date: _____

Signature of dentist

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 or office referring you to our practice: _____