

Patients Name:		Nickname:		Today's Date:	
Address:		City:		State:	Zip:
Home Phone:		Work Phone:		Cell Phone:	
E-mail:		Date of Birth:		Soc. Sec. #:	
Primary Dental Guarantor:			Home Phone:		
Secondary Dental Guarantor:			Home Phone:		Work Phone:
Physician Name:		Physician Phone:		Work Phone:	
Pharmacy:		Pharmacy Phone:			

Sex:	<input type="checkbox"/>	Females, please answer the following questions: Yes No <input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> <input type="checkbox"/> Are you nursing?	Please answer the following questions: Yes No <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco?	Height: <input type="text"/> Weight: <input type="text"/> BP: <input type="text"/> HR: <input type="text"/>
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<table style="width:100%;"> <tr><th>Yes</th><th>No</th><th>CONDITIONS</th></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol Abuse</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina Pectoris</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Bones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input 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Current Medications and Supplements:

Yes	No	ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Yes No
 Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below.

Signature: _____ Date: _____
(if under 18, parent or guardian signature required)