

BOLLINGER CANYON DENTAL WELCOMES YOU

Patient Information

Name _____ E-Mail: _____ D.O.B. _____
SS# _____ Home Ph # _____ Work/Cell # _____

Address _____ City _____ State _____ Zip _____
Sex: M / F Family Status: _____ Emergency Contact Name and Ph # _____

Responsible Party

Responsible person for account _____ Relation to Patient _____ SS# _____

Address _____ Phone _____ Driver License# _____

Health History

Family Physician: _____ Ph# _____

Are you currently taking any medication? YES NO

If so for what? _____

Have you been seen by an E.N.T.? YES NO

Any major operations or serious illnesses?

Check if you have or had any of the following:

- | | |
|------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Fen-phen |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney disease/transplants |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Cancer/radiation/chemotherapy |
| <input type="checkbox"/> Artificial heart valves/joints, implants etc. | <input type="checkbox"/> Asthma/lung disease /Tuberculosis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy/psychiatric problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant Due date: _____ |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Other conditions: |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Birth control pill |

Do you have any allergies to any medications: YES NO

If so, what? _____

Do you have or have had any *disease* or condition not listed? YES NO

If so, what? _____

Have you ever had any cosmetic procedure? YES NO

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or any minor child, ever have change in health. Should further information be needed, you have my permission to request my health care provider to release the information to you.

Patient/Parent/Legal Guardian Signature Date

Recall Signature Date

Recall Signature Date

Recall Signature Date

