James L. Burk, D.D.S.
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Patient Information

Patient Name:____ Date:______________
Last, First MI (Preferred Name)

E-Mail: ______________________________ Gender:______ Marital Status:________________

Social Security #:_________________________ Birth Date:____________________________

Phone (Home):___________ (Work):___________ Ext: ______(Mobile): ____________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

DO YOU HAVE ANY OF THE FOLLOWING DISEASES, ALLERGIES OR HEALTH CONCERNS?

- ☐ Stroke
- ☐ Head injuries
- ☐ Heart Disease or Attack
- ☐ Hepatitis A B C
- ☐ Latex Allergy
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chemotherapy Treatment
- ☐ Diabetes
- ☐ **Pregnancy**
  Due date:_________
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Asthma/Shortness of Breath
- ☐ High/Low Blood Pressure
- ☐ Hearing Loss/Hearing Aid
- ☐ Glaucoma
- ☐ Scarlet/Rheumatic Fever
- ☐ Stomach Ulcers
- ☐ Fainting/Dizzy Spells
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Kidney/Liver Disorders
- ☐ Heart murmur/mitral valve
- ☐ Hives or Skin Rash
- ☐ Herpes
- ☐ Arthritis

Allergies to any of the following:

- ☐ Penicillin ☐ Amoxicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Antibiotics: ___________
- ☐ Aspirin
- ☐ Acetaminophen/Ibuprofen
- ☐ Local Anesthetics
- ☐ Epinephrine
- ☐ Sedatives
- ☐ Codeine ☐ Iodine
- ☐ Halcion ☐ Valium
- ☐ Other_______________

- Do you have a history of addiction? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you currently taking any medications or supplements? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been treated for any serious illness? ☐ Yes ☐ No
  If yes, please explain:____
- Do you have a hip, knee, other joint replacement or reconstructive surgery? ☐ 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 doctor at the next appointment without fail.

I agree to provide this office a 24 hour notice of a change or cancellation of my appointment to avoid a charge.

____Date: _______________
Signature of patient, parent or guardian