

Patient Information

Name _____

Address _____
Last First Middle Initial
City State Zip

Date of Birth ____/____/____

Home # ____ - ____ - ____ Work # ____ - ____ - ____ Cell # ____ - ____ - ____

Drivers License # _____ Social Security # ____ - ____ - ____

Employer _____ Occupation _____ Email Address: _____

Spouse Name _____ Work # ____ - ____ - ____

Do you have Dental Insurance? _____ Parent/Guardian name if minor _____

Person to contact in case of emergency _____

Relationship _____ Phone # ____ - ____ - ____

Who may we thank for referring you? _____

Please circle Y (yes) or N (no) as applicable

Do you have or ever had any of the following?

Hypoglycemia, Diabetes	Y/N	Prosthetic Valves/Joints/Implants	Y/N
Heart Attack/Heart Trouble	Y/N	Stroke	Y/N
Hay Fever/Asthma/Allergies	Y/N	Heart Murmur/Mital Valve Prolapse	Y/N
High Blood Pressure	Y/N	Rheumatic Fever	Y/N
Circulatory Problems	Y/N	Anemia/Blood Disorder	Y/N
Hepatitis/Jaundice	Y/N	Excessive Bleeding	Y/N
Lung Problems/Tuberculosis	Y/N	Fainting/Blackouts	Y/N
Epilepsy/Seizures	Y/N	Nervous Disorders	Y/N
Blood Transfusions	Y/N	Headaches/Migraines	Y/N
Facial or Head Injuries	Y/N	Kidney Problems	Y/N
Radiation/Chemotherapy	Y/N	Glaucoma/Eye Problems	Y/N
Malignancies/Caners	Y/N	Ulcers/Digestive Problems	Y/N
Sinus Problems	Y/N	History of Eating Disorders	Y/N
AIDS/ARC	Y/N	Are you pregnant now?	Y/N
HIV Positive	Y/N	Prolonged Bleeding	Y/N
Arthritis/Rheumatism	Y/N	Blood Pressure _____	
Venereal Diseases	Y/N		

Name of Physician _____ Date of last physical ____/____/____

Have you been hospitalized in the last 2 years? If yes please explain _____

Do you consume alcohol or use tobacco? Y/N

Please list medication allergies _____

Please list any drugs being taken currently _____

Reason for this dental visit _____

Date of last dental visit ____/____/____ What was done at that time? _____

Have you ever been treated by a periodontist/orthodontist/or endodontist? Y/N

Please explain _____ Date last x-rays ____/____/____

Are you happy with the appearance of your teeth? Y/N

Patient Signature _____ Doctor Signature _____