PATIENT INFORMATION

Name ______________________ Preferred Name ______________

Date of Birth __________ SSN ____________ Male / Female Marital Status: M / S / Child

Address ____

City ____________________ State ________ Zip __________

Home Phone ____________ Work ____________ Cell ____________

Would you like to receive text message appointment reminders? Yes / No

Preferred E-mail (for appointment reminders) ______________________

Employer ____

Person Responsible for Payment ______________ Relationship __________

Referred By ____

MEDICAL HISTORY

		Yes	No
1.	Are you presently receiving any medical treatment? ________	[ ]	[ ]
2.	Have you had any major operations? ________	[ ]	[ ]
3.	Do you have any allergies? ________	[ ]	[ ]
4.	Are you presently taking any medications? ________	[ ]	[ ]
5.	Have you ever had hepatitis or jaundice? ________	[ ]	[ ]
6.	Have you ever had a blood transfusion? ________	[ ]	[ ]
7.	Are you pregnant? ________	[ ]	[ ]

8. Check any conditions that apply to you:

[ ]	Heart Trouble	[ ]	AIDS or HIV pos.	[ ]	Hives or Rash
[ ]	Heart Murmur	[ ]	Thyroid Disease	[ ]	Asthma/Hayfever
[ ]	High Blood Press.	[ ]	Kidney Disease	[ ]	Diabetes
[ ]	Rheumatic Fever	[ ]	Liver Disease	[ ]	Arthritis
[ ]	Epilepsy	[ ]	Ulcers/Stomach	[ ]	Anemia
[ ]	Venereal Disease	[ ]	Sinus Problems	[ ]	Tuberculosis
[ ]	Stroke	[ ]	Cancer		

		Yes	No
9.	Have you ever had excessive bleeding? ________	[ ]	[ ]
10.	Do you have at present have any dental complaints? ________	[ ]	[ ]
11.	When was your last full mouth x-ray taken? ________	[ ]	[ ]
12.	Explain any unusual medical or dental problems. ________	[ ]	[ ]

Signature ______________________________ Date ____________