Patient Information

Patient Name_______________________________ Date_______________

______Male ______Female ____Married ____Single ____Child ____Other

Social Security #_________________ Birth Date_______________

Home Phone_________________ Work Phone_____________ Ext_______

Address____

____

Health Information

Date of last Dental visit_______________ Reason for this visit_________________

Have you ever had any of the following? Please check all that apply:

__ Aids/HIV	__Fainting	__Nervous Disorders	__Ulcers
__Allergies	__Glaucoma	__Pacemaker	__Venereal Disease
__Anemia	__Hay Fever	__Radiation Treatment	__Sulfa allergy
__Arthritis	__Head Injuries	__Penicillin Allergy	__Smoking
__Artificial Joint	__Heart Disease	__Respiratory Problems	__Blood Transfusion
__Asthma	__Heart Murmur/MVP	__Rheumatic Fever	__Latex Allergy
__Blood Disease	__Hepatitis	__Rheumatism	__Tumors
__Cancer	__High Blood Pressure	__Sinus Problems	
__Diabetes	__Jaundice	__Stomach Problems	
__Dizziness	__Kidney Disease	__Stroke	
__Epilepsy	__Liver Disease	__Tuberculosis	
__Growths	__Excessive Bleeding	__Mental Disorders	

1. Are you currently taking any medications? Please list______________________________
2. Have you ever taken any medications or drugs in the past including fen-phen or dexfenfluramine or fenflurameine?______________________________________
3. Are you allergic to any medications or anesthetics?______________________________
4. Are you pregnant or nursing?______________________________________
5. Have you had any complications following dental treatment?__________________
   If yes, explain____
6. Have you been admitted to a hospital or needed emergency care in the past two years?____
   If yes, explain____
7. Are you under the care of a physician now?_________________
   If yes, explain____
8. Name of Physician________________________ Phone____________________
9. Do you have health issues that need further clarification?_______________
   If yes, explain____
10. Do you have or have you had any condition, disease or problem not listed? __________
11. Do you now smoke or have you ever smoked? ______________________________

To the best of my knowledge, all of the preceeding answers and information provided are true and correct, If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date__________________________

Signature of patient, parent or guardian

Whom May we thank for referring you to our Office? ______________________________

Charges will be accessed for broken appointments without a 24-hour notice.