

Patient Information

Patient's Name _____
Last First Middle

Address _____
City State Zip

Telephone (____) _____ (____) _____
Home Work

Birthdate _____ Age _____ Male Female

By What Name do you wish to be addressed? _____

SS # _____ Occupation _____

Guardian's name if patient is a minor _____

Whom may we thank for referring you? _____

In case of emergency, contact _____
Name

Relationship _____ Home Phone _____ Work Phone _____

Billing Information

Person responsible for this account _____

Address _____
City State Zip

Telephone (____) _____ (____) _____
Home Work

Birthdate _____ Relationship to Patient _____

SS # _____ Drivers Lic # _____

Occupation _____ Employer _____

Years at this job _____ Single Married Widowed Divorced
Years Months

How do you prefer to handle this account? (after insurance, if applicable)
 Cash Credit Card Other _____

Spouse's Name _____ Birthdate _____

Employer _____ Work Phone (____) _____

Medical History

Are you currently under a physician's care? Yes No If so, for what reason? _____

Physician's Information _____
Dr's Name Address City State Zip Phone

Please mark any of the following you may have had, or have at present-

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cold sores or herpes |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Surgical Prosthesis | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Ulcers/Stomach problems | <input type="checkbox"/> Fainting or dizzy spells | Do you or have you used: |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cancer or related treatment | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Illegal IV drugs |
| <input type="checkbox"/> Heart Attack or Heart Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood thinning treatment | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Hay Fever | |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies or Hives | |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Sinus trouble | |

For women only-

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Do you take birth control? Yes No

Inner Ear disorders or Surgery

Have you ever been requested to take antibiotics or other medications before a dental appointment? Yes No

Is there anything else we should know about your health that is not covered in this form? Yes No

Would you like to speak with the doctor privately about any matter? Yes No

Medications

List all medications and dietary supplements you have taken in the last 3 months. Include dosage and reason for taking the medication _____

Allergies

Mark all medications or health care related substances to which you have experienced an allergic or adverse reaction:

Penicillin Sulfa drugs Others _____

Codeine Epinephrine _____

Latex Local Anesthetics None

I certify that the above information is complete and accurate-

Patient or Guardian's signature _____ Date _____

Dentist's signature _____ Date _____