

Patient Information

 Last First Middle

 Address City State Zip

 Home phone Work phone
 Birthdate _____ Age _____ M / F
 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 _____

 Relationship Home Phone Work Phone

Billing Information

Person responsible for this account _____

 Address City State Zip

 Home phone Work phone
 Birthdate _____ Age _____ M / F
 SS # _____ Drivers Lic # _____
 Occupation _____ Employer _____
 Years at this job _____ Single Married Widowed Divorced

 YY / MM
 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

- Rheumatic Fever
- Heart Murmur
- Congenital Heart Disease
- Artificial Heart Valve
- Pacemaker
- High / Low Blood Pressure
- Heart Attack or Heart Disease
- Blood thinning treatment
- HIV or AIDS
- Hepatitis or Liver Disease
- Venereal Disease
- Inner Ear disorders or Surgery
- Artificial Joint
- Surgical Prosthesis
- Ulcers/Stomach problems
- Cancer or related treatment
- Kidney trouble
- Diabetes
- Glaucoma
- Scarlet Fever
- Thyroid Disease
- Tuberculosis
- Arthritis / Rheumatism
- Stroke
- Epilepsy or seizures
- Fainting or dizzy spells
- Psychiatric treatment
- Leukemia
- Bruise easily
- Asthma
- Hay Fever
- Emphysema
- Allergies or Hives
- Sinus trouble
- Cold sores or herpes
- Other _____

Do you or have you used:

Tobacco Yes No
 Alcohol Yes No
 Illegal IV drugs Yes No
 Other _____

For women only-

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

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 Signature Date

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