

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

Male Female Married Single Child Other _____

Social Security # : _____ Date of Birth: _____

Phone Home: _____ Work: _____ Cell: _____

Address: _____
Street Apartment #
City State Zip Code

E – Mail Address: _____

Date of last dental visit: _____ Reason for this visit: _____

HEALTH INFORMATION

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental/Nervous Disorders | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Tobacco Usage |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | Due Date _____ | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | _____ |

• Do you take any over the counter medications? Yes No
If yes, please list: _____

• Do you take any prescription medications? Yes No
If yes, please list: _____

• Do you currently take vitamins, supplements or aspirin on a regular basis? Yes No
If yes, please list: _____

• Have you ever or are you currently taking medication for the treatment of osteoporosis? Yes No
If yes, please list: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

• Are you seeing a physician for other than routine care? Yes No
If yes, please explain: _____

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

Signature of patient, parent or guardian Date: _____