Patient Information

Patient Name: _____ Date:_____
Last, First, MI (Preferred Name)

Gender:_____ Marital Status: _____ Other:_____

Social Security #: _____ Birthdate: _____ E-Mail_____

Phone (Home): _____(Work): _____ Ext: _____ (Cell): _____

Address: _____
Street City State Zip Code

Occupation: _____ Spouse's Name:_____

Child/Children's Names: _____

Health Information

Date of Last Dental Visit: _____Date of Last Hygiene Visit: _____ Reason for this visit: _____

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

[]AIDS
[]Anemia
[]Arthritis
[]Artificial Joints
[]Asthma
[]Blood Disease
[]Cancer Type_____
[]Diabetes
[]Dizziness, Vertigo
[]Epilepsy
[]Excessive Bleeding
[]Fainting
[]Glaucoma
[]Head injuries
[]Heart Disease, Angina Artificial Valve
[]Heart Murmer, Rheumatic Fever, MVP
[]Hepatitis A B C
[]Herpes
[]High Blood Pressure
[]HIV+
[]Jaundice
[]Kidney/Liver Disease
[]Psychiatric/Psychological Care
[]Nervous Disorders
[]Pacemaker
[]Pregnancy
[]Radiation Treatment
[]Respiratory Problems
[]Stomach Problems: Ulcers, Acid Reflux, IBS
[]Tatoos, Body Piercing
[]Tuberculosis
[]Tumors, Cysts
[]Transfusions
[]Transplant(s)
[]Sexually Trasmitted Disease
[]Codeine Allergy
[]Drug Allergies: Codeine, Penicillin, Aspirin, Epinephrine
[]Other Allergies: _____
[]Latex Allergy

- Have you ever had any complications following dental treatment? [] Yes [] No
  If yes, please explain: _____

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

Name of Physician: _____ Phone: _____

Patient or Responsible Party Information

The following is for [] the patient's spouse [] the person responsible for payment

Name: _____

Social Security #: _____ Birthdate: _____

Phone (Home): _____(Work): _____(Cell)_____

E-Mail: _____

Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? _____

_____Date _____ Relationship of Patient:_____
Signature of patient, parent of guardian