

Date _____

PATIENT INFORMATION

Dr.
 Mr.
 Mrs.
 Name: Ms. _____ Last _____ First _____ Middle _____ Email: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ SS#: _____

Spouse/ Parent Employer: _____ Date of Birth: _____

Dental Insurance: _____ Name of Policyholder: _____ ID#: _____

Who Referred You To Us? _____

Previous Dentist / Address _____ Phone: _____

MEDICAL HEALTH

Physician's Name: _____ Phone: _____

Physician's Address: _____

Last Physical: _____ Findings: _____

Emergency Contact: _____ Phone: _____

Are you presently taking any medications? Yes No Type/Purpose _____

Are you allergic to any medications? Yes No If so, please list _____

Do you have, or had any of the followings:

	Yes	No		Yes	No
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you a smoker or ever been?.....	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve or hip.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease (Anemia).....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Tumor History.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immune Deficiency HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you subject to prolonged/excessive bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy or Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HEALTH

Date of last dental exam: _____

What is your immediate dental concern or reason for today's appointment? _____

Do you have any specific questions concerning your health, teeth or gums? _____

Patient Signature _____