Patient Information

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

Gender: Male _____ Female_____ Patient Social Security #_____ Birthdate: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Employer: _____ Job Title: _____

Who may we thank for referring you to our office? _____

Emergency Contact: _____ Relationship: _____

Email address for appt. confirmations: _____ Text Message Confirmation? Yes No

Health Information

Please check Yes (Y) or No (N) if you have or have ever had the following:

Y N
☐ ☐ AIDS/HIV
☐ ☐ Allergies:
Drug:_____
Food:_____
Environment:_____
☐☐ Anemia
☐☐ Arthritis
☐☐ Artificial Joints
☐☐ Asthma
☐☐ Blood Disease
☐☐ Cancer
☐☐ COPD
☐☐ Diabetes
☐☐ Eating Disorder
☐☐ Emphysema
☐☐ Epilepsy
☐☐ Excessive Bleeding
☐☐ Eye Surgery
☐☐ Fainting
☐☐ Fibromyalgia
☐☐ Glaucoma

Y N
☐☐ Growths/Tumors
☐☐ Hard of Hearing
☐☐ Hay Fever
☐☐ Head Injuries
☐☐ Heart Disease
☐☐ Heart Murmur
☐☐ Hepatitis:
Type: A B C
☐☐ Herpes
☐☐ High Blood Pressure
☐☐ Jaundice
☐☐ Kidney Disease
☐☐ Liver Disease
☐☐ Mental Disorders
☐☐ Mitral Valve Prolapse
☐☐ Nervous Disorders
☐☐ Pacemaker
☐☐ Pregnancy
Due date:_____

Y N
☐☐ Radiation Treatment
☐☐ Recreational Drugs
☐☐ Respiratory Problems
☐☐ Rheumatic Fever
☐☐ Rheumatism
☐☐ Sinus Problems
☐☐ Sleep Apnea
☐☐ CPAP
☐☐ Stomach Problems
☐☐ Stroke
☐☐ Swollen Neck Glands
☐☐ Osteoporosis Med:
Current Previous
☐☐ Thyroid Disease
☐☐ Tobacco Use
☐☐ Tuberculosis
☐☐ Ulcers
☐☐ Venereal Disease

☐ Other:_____
_____
_____

Please list below all medications you currently take or provide a copy of all medications you are taking

_____
_____
_____
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

_____ Date: _____
Signature of patient, parent or guardian