PATIENT'S INFORMATION

PATIENT'S NAME ______________________ E-MAIL ADDRESS ______________________

ADDRESS ______________________ PHONE ______________

CITY ______________ STATE ________ ZIP ____________ CELL PHONE ______________

EMPLOYER ______________________ POSITION ______________

ADDRESS ______________________

CITY ______________ STATE ________ ZIP ____________ PHONE ______________

PHYSICIAN NAME ______________________ PHONE ______________

SPOUSE NAME ______________________ WORK PHONE ______________

NAME OF RESPONSIBLE PARTY ______________________

DENTAL INSURANCE ☐ Yes ☐ No CARRIER ______________________

GROUP NAME & NUMBER ______________________

PATIENT'S AGE ________ SEX ________ HEIGHT ________ WEIGHT ________ BIRTHDATE ______________

DATE OF LAST PHYSICAL EXAMINATION ______________ CURRENTLY UNDER MEDICAL TREATMENT ☐ Yes ☐ No

CURRENTLY TAKING ANY MEDICATION OR DRUGS ☐ Yes ☐ No NAME ______________________

HOW LONG SINCE LAST DENTAL VISIT ________ X-RAYS ________ ______________________

HAVE YOU EVER BEEN A SMOKER? ☐ Yes ☐ No

Medical History Indicate which of the following you have had or have at present.

	Yes	No		Yes	No
Heart Failure	☐	☐	X-ray or Cobalt Treatment	☐	☐
Heart Disease or Attack	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐
Angina Pectoris	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Rheumatism	☐	☐
Heart Murmur	☐	☐	Cortisone Medicine	☐	☐
Rheumatic Fever	☐	☐	Glaucoma	☐	☐
Congenital Heart Lesions	☐	☐	Pain in Jaw Joints	☐	☐
Scarlet Fever	☐	☐	A.I.D.S.	☐	☐
Artificial Heart Valve	☐	☐	Hepatitis A (infectious)	☐	☐
Heart Pacemaker	☐	☐	Hepatitis B (serum)	☐	☐
Heart Surgery	☐	☐	Liver Disease	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Yellow Jaundice	☐	☐
Anemia	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Drug Addiction	☐	☐
Kidney Trouble	☐	☐	Hemophilia	☐	☐
Ulcers	☐	☐	Venereal Disease		
Cosmetic Surgery	☐	☐	(Syphilis, Gonorrhea)	☐	☐
Emphysema	☐	☐	Cold Sores	☐	☐
Cough	☐	☐	Fever Blisters	☐	☐
Tuberculosis (TB)	☐	☐	Epilepsy or Seizures	☐	☐
Asthma	☐	☐	Fainting or Dizzy Spells	☐	☐
Hay Fever	☐	☐	Nervousness	☐	☐
Sinus Trouble	☐	☐	Psychiatric Treatment	☐	☐
Allergies or Hives	☐	☐	Use of Tobacco Products	☐	☐
Diabetes	☐	☐	Bruise Easily	☐	☐
Thyroid Disease	☐	☐	Currently Pregnant	☐	☐

ALLERGIC TO ANY MEDICATION OR DRUG ☐ Yes ☐ No WHICH ______________________

DO YOU HAVE ANY DISEASE OR PROBLEM NOT LISTED? LIST ______________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

SIGNATURE ______________________ DATE ______________

RESPONSIBLE PARTY SIGNATURE ______________________ DATE ______________