

Date _____

PATIENT INFORMATION

Name: ^{Dr.} ^{Mr.} ^{Mrs.} ^{Miss} _____ Email: _____

Home Address: _____ Last First Middle Phone: _____

City: _____ State: _____ Zip: _____

Business Address: _____ Phone: _____

Employer: _____ Occupation: _____

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

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

Spouse/Parent - Employer: _____ Date of Birth: _____

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 have you had any of the following:

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Do you have an artificial heart valve or hip? | <input type="checkbox"/> | <input type="checkbox"/> |
| Bacterial Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice/Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis or Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease (Anemia) | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Lesions | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumor History | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you subject to prolonged/excessive bleeding? | <input type="checkbox"/> | <input type="checkbox"/> | Acquired Immune Deficiency Syndrome | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HEALTH

Date of last dental examination: _____

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 _____