

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name) Gender: _____ Marital Status: _____
Social Security #: _____ Birth Date: _____ E-Mail: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Mobile/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:

- | | | | |
|---------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease, Angina,
Artificial Valve | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Drug Allergies:
Codeine, Penicillin, Aspirin, Epine |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur, Rheumatic
Fever, MVP | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Other Allergies: _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory Problems | Medications Currently Taking:
(Please enter information on Pink
History Form) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems,
Ulcers, Acid Reflux, IBS | |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Tattoos, Body Piercing | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Dizziness, Vertigo | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Tumors, Cysts | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric/Psychological
Care | <input type="checkbox"/> Transfusions | |
| <input type="checkbox"/> Excessive Bleeding | | <input type="checkbox"/> Transplant(s) | |
| <input type="checkbox"/> Fainting | | <input type="checkbox"/> Sexually Trans. Disease | |
| <input type="checkbox"/> Glaucoma | | | |

• 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 #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City State Zip Code

Referral Information

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

Signature of patient, parent or guardian _____ Date _____ Relationship of Patient: _____