

Patient Information -- Please Complete Page 1 and 2

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

Social Security #: _____ Birth Date: _____ E-mail: _____ (for quarterly newsletter only)

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

Address: _____
Street City State Zip Code

Emergency Contact: _____
Name Phone Number Relationship

Medical History

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths/Tumors | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other Medical Condition |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis | Explain: _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Reaction to Anesthetic | Due date: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Steroid Therapy | |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney Disease | |

/	Blood Pressure
Date	

Yes No

- Have you been admitted to a hospital in the past two years? If so for what? _____
- Under active treatment by a physician? If so for what? _____
- Are you taking any drugs or medications? If so, what? _____
- Are you allergic or have reacted adversely to any drugs or medications? If so, what? _____
- Have you ever been told to take antibiotics prior to a dental appointment? _____

Dental History

Date of Last Dental Visit: _____ Reason for today's visit: _____

Yes No

- Have you ever had any complications following dental treatment? Explain? _____
- Do you have pain in your teeth because of heat, cold, or sweets? Explain? _____
- Are you nervous about receiving dental treatment?
- Do your teeth hurt when you chew or do you avoid chewing on any teeth?
- Did any of your family members lose their teeth at an early age?
- Are you pleased with your smile?

Medical Alert:

Please check what you feel are your present dental needs:

- | | |
|---|--|
| <input type="checkbox"/> Routine exam/ consultation | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Cleaning teeth / gum treatment | <input type="checkbox"/> Dentures – Full / Partial |
| <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Root canal (Endodontic therapy) |
| <input type="checkbox"/> Fillings | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Crowns/bridges | <input type="checkbox"/> Emergency (pain relief) |

I certify that all health information above is correct: _____
Patient/Guardian Signature Date Doctor Review Date

Referral Information

Whom may we thank for referring you to our practice?

- Another patient - Name: _____ Another Dental Office - Name: _____
- Yellow Pages Newspaper School Work Other _____

Office Use – In the future, please advise us of any changes in your medical history or any new medications you may be taking. Continue to P.2

Date of Review:	Changes to your health history?	Patient Initial:	Blood Pressure	Date
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

