

Welcome

Dr. Allen and his staff are dedicated to providing quality care to help you attain optimal oral health. Please complete this form so we are able to provide the best treatment for you.

Personal Information

Today's Date: _____

Last Name: _____ First: _____ Middles: _____

I refer to be called: _____ Male Female

Birthdate: _____ Age: _____ SS #: _____ DL #/State: _____

Home Address: _____

City/State: _____ Zip: _____

Email Address: _____

Phone Home #: _____ Work #: _____ Cell #: _____

Patient's Employer: _____

If Child, Guardian Information

Last Name: _____ First: _____ Middles: _____

Phone Home #: _____ Work #: _____ Cell #: _____

Birthdate: _____ SS #: _____ DL #/State: _____

Spouse Information

Last Name: _____ First: _____ Middles: _____

Birthdate: _____ SS #: _____ DL #/State: _____

Spouse's Employer: _____

When/Where best times to reach you? _____

Who may we thank for referring you? _____

Payment is due in full at time of treatment.

Medical History

Do you have a personal physician? Yes No Physician's Name: _____
Phone: (____) _____ Date of Last Visit: _____

Your current physical health is: Good Fair Poor

Do you use tobacco in any form? Yes No If so, how much? _____

Do you need antibiotics before dental treatment? Yes No

For Women: Are you taking Birth Control Pills? Yes No
Are you pregnant? Yes No Week #: _____

Please list any prescription/over-the-counter drugs you are taking:

Have you ever had any of the following diseases or medical problems?

- | | |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding/Hemophilia | Y N Herpes/Fever Blisters |
| Y N AIDS | Y N High Blood Pressure |
| Y N Alcohol/Drug Abuse | Y N HIV |
| Y N Anemia | Y N Hospitalized for Any Reason |
| Y N Arthritis | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Disease |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood Transfusion | Y N Lupus |
| Y N Cancer/Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Pacemaker |
| Y N Congenital Heart Defect | Y N Psychiatric Problems |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema | Y N Seizures |
| Y N Epilepsy | Y N Shingles |
| Y N Fainting Spells | Y N Sickle Cell Disease/Traits |
| Y N Frequent Headaches | Y N Sinus Problems |
| Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid Problems |
| Y N Heart Attack/Surgery | Y N Tuberculosis |
| Y N Heart Murmur | Y N Ulcers |
| Y N Hepatitis | Y N Venereal Disease |

Please list any other serious medical conditions you have ever had: _____

Are you allergic to any of the following?

- | | | |
|------------------------|--------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Iodine |
| Y N Codeine | Y N Jewelry/Metals | Y N Penicillin |
| Y N Dental Anesthetics | Y N Latex | Y N Tetracycline |

Please list any other drugs/materials that you are allergic to: _____

I confirm that the information that I have given today is correct to the best of my knowledge.

Signature: _____ Date: _____