Patient Information

Patient Name: ____ **Date:** _______________
LAST FIRST MI

If the patient is a minor, give name of parent or legal guardian: ______________________________

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other** _______________

Social Security #: _________________ Birth Date: ___________ Weight: ________ Height: ________

Phone (HOME): _________________ (WORK): __________________ (CELL): ________________

Address: __________________________________ EMAIL: ______________________________

____
CITY STATE ZIP CODE

MEDICAL HISTORY

Date of last Dental Visit: _________ Name of Dentist: ________________ Reason for Visit: _____________

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

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

☐ HIV / AIDS	☐ Epilepsy	☐ Ulcers	☐ Thyroid Problems
☐ Allergies	☐ Excessive Bleeding	☐ Mental Disorders	☐ Tuberculosis
☐ Fainting	☐ **Mitral Valve Prolapse**	☐ Tumors	
☐ **Aspirin Allergy**	☐ Glaucoma	☐ Nervous Disorders	
☐ Anemia	☐ Growths	☐ Pacemaker	
☐ Arthritis	☐ Hay Fever	☐ **Penicillin Allergy**	
☐ **Artificial Joints**	☐ Head Injuries	☐ Radiation Treatment	
☐ Asthma	☐ Heart Disease	☐ Respiratory Problems	
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Cancer	☐ Hepatitis _____	☐ Rheumatism	
☐ **Codeine Allergy**	☐ High Blood Pressure	☐ Sinus Problems	
☐ Diabetes:Type __	☐ Jaundice	☐ Stomach Problems	
☐ Dizziness	☐ Kidney Disease	☐ Stroke	
☐ Drug Addiction	☐ Liver Disease	☐ **Taking Aspirin Daily**	
☐ Emphysema	☐ Leukemia	☐ Venereal Disease	

Have you ever taken an OSTEOPOROSIS medication? Y / N
(EX: Fosamax/Actonel/Boniva/Aredia/Zometa)
Med taken? _____________________
Started : ___________________
Stopped: ____________________

Does dental treatment make you nervous?
☐ Slightly ☐ Moderately ☐ Extremely
Would you prefer to be sedated for surgical procedures?
☐ Yes ☐ No
____

For Women ONLY
Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

Are you allergic to any medication? Have you ever had an allergic reaction to a medication?
If yes, describe: ____

Are you taking any medications at this time? If yes, please list on Medication Information Form.

Have you ever had to pre-medicate with antibiotics for dental treatments? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: ______________________
____

Name of Physician: ___________________________________ Phone #: __________________________

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____

Do you use tobacco? ☐ Yes ☐ No If yes, What and How often? _______________________________

Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor.
If you prefer photographs not be taken, please check box. ☐ **No photographs**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: ____ Date: _________

Previous Surgeries:

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