

Patient And Responsible Party Information

Patient Name: _____ Date: _____
 Last First MI
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____ Driver's License # _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
 Address: _____
 Street E-Mail Address
 City State Zip Code
 Spouse Name or Responsible Party for a Minor: _____ DOB: _____
 Social Security # _____ Driver's License# _____
 Phone & Address (if different from above) _____

Health Information

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

<input type="checkbox"/> AIDS, HIV +/-or ARC	<input type="checkbox"/> Hepatitis -- Type: _____	<input type="checkbox"/> Abnormal bleeding associated with extractions	Are you happy with the appearance of your smile? Yes _____ No _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> High/Low Blood Press	<input type="checkbox"/> Medication allergies? Please list _____	Do you wish your teeth were whiter? Yes _____ No _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Been advised to take antibiotics prior to dental treatment for preventive reasons?	Name of former dentist: _____
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Complications following dental treatment?	Date last seen: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Metal Allergies	Please list all drugs (prescription; OTC and herbal) you are taking: _____	<u>Name, Address & Phone Numbers of a friend or a relative (other than your spouse) who we may contact in case we are unable to locate you</u>
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Migraine Headaches	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mitral Valve Prolapse	_____	_____
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Pacemaker Year placed _____	_____	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Currently pregnant Due date: _____	_____	_____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Radiation Treatment	_____	_____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rheumatic Fever	_____	_____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sinus Problems	_____	_____
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Stomach Problems	_____	_____
<input type="checkbox"/> Fainting	<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Fearful or anxious	<input type="checkbox"/> Tobacco use	_____	_____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis	_____	_____
<input type="checkbox"/> Growths	<input type="checkbox"/> Ulcers	_____	_____
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Codeine Allergy	_____	_____
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Penicillin Allergy	_____	_____
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Adverse reaction to dental anesthetics	_____	_____
<input type="checkbox"/> Heart Surgery			
<input type="checkbox"/> Heart Murmur			
<input type="checkbox"/> Heart Valve Replacmt			

- Are you now under the care of a physician for an on-going or chronic health problem? Yes No
If yes, please explain _____
- Name of Physician: _____ Phone: _____

I have reviewed my medical history and I have made appropriate changes if necessary and I certify the above information is accurate.

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have any changes in my medical or health status, I promise to notify the doctors at my next appointment.

Signature of patient, parent or guardian _____ Date: _____

Whom may we thank for referring you to our practice?

A patient A dentist or physician Radio Ad – Name of station _____ Employee of this office Yellow Pages

Newspaper Smile Cards Name of person or office referring you to our practice: _____

