PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____
Last First Dr., Mr., Mrs., Miss, Ms

Home Address _____ Home Phone _____
Address Street City Zip

Spouse's Name _____ If minor, parent or guardians' names _____

Your Employer _____ How long? _____ Soc. Sec. No. _____

Business Address _____ Business Phone _____
Address Street City Zip

Spouse's Employer _____ Spouse's Soc. Sec. No. _____ Number of Dependents _____

How long since you have been to a dentist? _____ Former Dentist _____

Reason for this dental appointment _____

Whom may we thank for referring you to this office? _____

Person financially responsible _____ Do you have Dental Insurance? _____

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you in general good health at this time?	☐	☐
2. Has there been any change in your general health within the past year?	☐	☐
3. Name and phone number of physician _____		
4. Approximate date of last physical exam _____ Are you under the care of a physician now?	☐	☐
5. If so, what is the condition being treated? _____		
6. Have you ever been hospitalized or had any serious illness or surgery?	☐	☐
7. If so, what? _____		
8. Are you presently wearing a heart pacemaker?	☐	☐
9. Are any of your joints replacements, or are there any metal pins, rods, screws, or plates placed permanently in your body?	☐	☐
10. Do you bleed excessively when you get cut?	☐	☐
11. Do you have or has a physician ever informed you that you've ever had:		
Rheumatic Fever or Rheumatic Heart Disease?	☐	☐
A Heart Condition?	☐	☐
High Blood Pressure?	☐	☐
Stroke?	☐	☐
Lung or Respiratory Disease?	☐	☐
Asthma?	☐	☐
Allergy or Hay Fever?	☐	☐
Hives or Skin Rash?	☐	☐
Fainting Spells or Seizures (Epilepsy)?	☐	☐
Diabetes?	☐	☐
Any Liver Disease, Yellow Jaundice or Hepatitis?	☐	☐
Any Kidney Disease?	☐	☐
Any Blood Disease or Anemia?	☐	☐
Tuberculosis?	☐	☐
HIV?	☐	☐
Venereal Disease?	☐	☐
12. Has you skin ever reacted to silver or any other metal jewerly?	☐	☐
13. Have you had surgery, X-Ray, or other treatments for a tumor or growth of your mouth or face or any other part of your body?	☐	☐
14. Are you taking any drugs or medications?	☐	☐
15. If so, what? _____		
16. Have you ever had any problems taking any of the following: Local Anesthetics (Novocaine, etc.):	☐	☐
Penicillin?	☐	☐
Sulfa Drugs or other antibiotics?	☐	☐
Barbiturates, Sedatives, or Sleeping Pills?	☐	☐
Aspirin?	☐	☐
Any Other Drug or Food? _____		
17. Women: Are you Pregnant? _____ Delivery Date _____		
18. Women: Are you taking birth control pills? (Some antibiotics prescribed by dentists interact with birth control pills)	☐	☐

Patient's Name