Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

Birth Date: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

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

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____ Social Security # _____

Health Information

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

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ **ARTIFICAL JOINTS**
- ☐ **ARTIFICAL HEART VALVE**
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Problems
- ☐ Eye Problems
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ **HEART MURMUR**
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ **MITRAL VALVE PROLAPSE**
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy (Currently)**
  Due date: _____
- ☐ Psychiatric Care/Counsel
- ☐ Radiation/Chemotherapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
- ☐ _____
- ☐ _____

Are you allergic to any of the following:

☐ Local anesthetics ☐ Penicillin ☐ Codeine ☐ Latex
☐ Sulfa ☐ Aspirin ☐ Other: : _____

- 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: _____
- Name of Primary Care Physician: _____ Phone: _____
- Are you now under the care of a specialist? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- List **ALL** medications you are currently taking. Include over the counter, prescriptions, and herbal supplements:

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.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____ Staff Initials: _____ Date: _____
Signature of Doctor