Patient Information

Preferred Name: _____

Name: _____ Single ☐ Married ☐ Male ☐ Female ☐

Address: _____ City: _____ Zip: _____

Birthdate: _____ SSN: _____

Contact Information: (Check where you would prefer to be called or contacted.)

Home Phone: _____ ☐ Cell # (text): _____ ☐

Work Phone: _____ ☐ Email: _____ ☐

Place of Employment or School? _____ **Occupation** _____

Dental Insurance Company Name? _____ **Secondary** _____

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

Medical History: (please answer yes or no)

Yes No		Yes No		Yes No		Yes No	
☐☐	Heart Murmur	☐☐	Lung Disease	☐☐	Artificial Heart Valve	☐☐	Premeds
☐☐	Angina/Chest Pain	☐☐	Allergies	☐☐	Heart Pacemaker	☐☐	Kidney Disease
☐☐	Heart Attack/Failure	☐☐	Sinus Problems	☐☐	Blood Disease	☐☐	Thyroid Disease
☐☐	Congenital Heart Disorder	☐☐	Asthma	☐☐	High Blood Pressure	☐☐	Snoring
☐☐	Mitral Valve Prolapse	☐☐	Low Blood Pressure	☐☐	Bleeds Easily	☐☐	Liver Disease
☐☐	Rheumatic Fever	☐☐	Hepatitis A, B or C	☐☐	Tested Positive for HIV	☐☐	Cancer
☐☐	Diabetes	☐☐	Tobacco Usage	☐☐	Fosamax or Bone Density Meds		
☐☐	Taking Fen-Phen	☐☐	Habitual Use of Controlled Substances				

Yes No

Are you currently under the care of a physician? Why? _____ ☐☐

Are you taking any medications? _____ ☐☐

Are you allergic to any medications? _____ ☐☐

Are you pregnant or suspect you maybe? ☐yes ☐no Are you taking Birth Control Pills?☐☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient Signature_____ Date _____

Doctor Signature_____ Doctor's Remarks _____