

DATE \_\_\_\_\_

# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions, please ask- we will be happy to help.*

## *Patient Information (Confidential)*

Soc. Sec.# \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's or Parent's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

## *Patient Medical History*

Physician \_\_\_\_\_

Date of Last Exam \_\_\_\_\_ Office Phone \_\_\_\_\_

Are you under medical treatment now? \_\_\_\_\_

Have you been hospitalized for any reason in the last 5 years? \_\_\_\_\_ If yes, please explain

Are you taking any medications, including non-prescription medicine? \_\_\_\_\_

If yes, what medications are you taking? \_\_\_\_\_

Are you allergic to anything or ever had a reaction to any medication? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

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## *Have you ever had any of the following?*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Heart Disease                | <input type="checkbox"/> Chest Pains           |
| <input type="checkbox"/> Heart attack          | <input type="checkbox"/> Cardiac Pacemaker            | <input type="checkbox"/> Easily winded         |
| <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Angina                       | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Swollen ankles        | <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Hay Fever/Allergies   |
| <input type="checkbox"/> Fainting/Seizures     | <input type="checkbox"/> Frequently tired             | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Radiation Therapy     |
| <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Glaucoma              |
| <input type="checkbox"/> Epilepsy/Convulsions  | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Recent Weight Loss    |
| <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> Heart Trouble         |
| <input type="checkbox"/> Kidney Diseases       | <input type="checkbox"/> Hepatitis/Jaundice           | <input type="checkbox"/> Respiratory Problems  |
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Problem       | <input type="checkbox"/> Stomach Troubles/Ulcers      | <input type="checkbox"/> Other _____           |

## *Women Only*

Are you pregnant or think you may be pregnant? \_\_\_\_\_

Are you nursing? \_\_\_\_\_ Are you taking oral contraceptives? \_\_\_\_\_

## *Authorization And Release*

I certify that I have read and understand the above information to the best of my knowledge.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

\_\_\_\_\_  
Patient Signature

For office Use Only

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_