

PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.*

Patient name _____ Birth date _____ Home phone _____
If minor, parents names _____ Cell phone _____ Work phone _____
Mailing address _____ City _____ State _____ Zip _____
Spouse name _____ Emergency Contact name/phone _____
Employer _____ Occupation _____
Email Address _____
Whom may we thank for referring you to our office _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

YES NO (Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hay fever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? YES NO

Name of your physician: _____

Please add anything else you would like us to know about

Signature of patient (or parent) _____

Date _____

Are you allergic to, or have you reacted adversely to any of the following?

YES NO

- Latex materials
- Penicillin
- Other antibiotics _____
- Local anesthetics ("Novocain")
- Codeine
- Other narcotics _____
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

YES NO

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptiv

