

Patient Information

Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Date Of Birth: _____ Social Security Number: _____ Marital Status: _____

Sex: _____ Email Address: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Name: _____ Physician Ph #: _____

Pharmacy: _____ Pharmacy Ph #: _____

Primary Dental Guarantor: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Secondary Dental Guarantor: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Patient Medical History

• Height: _____ Weight: _____

• Date of Last Visit: _____

• Date of Medical History: _____

• Check boxes for any of the following that you have had in the past or have presently:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Hepatitis A/B | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Smoke or Use Tobacco |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer - Chemotherapy | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Seizures | |

 • Is there any disease, condition, or problem not listed above that you think this office should know?..... Yes No

If so, please explain: _____

• Notes: _____

FOR OFFICE USE ONLY

ID: _____

BP: _____

Heart Rate: _____

MEDICAL ALERTS:

WOMEN ONLY

Yes No

- | | | | |
|--------------------------|--------------------------|-------------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control? | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? | • If yes, # of weeks: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? | |

Patient Medication Record

Full Name: _____

***Please list all medications you are currently taking (include prescription, over-the-counter, and herbal)**

I am not currently taking any medications

Medication Name	Dosage	Reason for Taking

Patient Allergy Record

***Are you allergic to or have you had an adverse reaction to:** (check box and explain)

I have no known allergies

Aspirin

Erythromycin

Metals

Codeine

Jewelry

Penicillin

Dental Anesthetic

Latex

Tetracycline

Other (List Below)

Signature: _____ Date: _____

(Parent or Legal Guardian if Minor)