PATIENT INFORMATION

Date _____

Name _____
First Middle Last

Social Security No. _____ Date of Birth _____

Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____

E-Mail _____

Employed by _____

Address _____

Phone Number where Employed _____

Person Responsible for this Account _____

Referred by _____

Who is your Physician? _____
In case of Emergency, name and
Phone # of relative or close friend _____

Former Dentist _____

PATIENT MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

1. Are you now under the care of a physician? Yes ❑ No ❑
   (a) If so, what is the condition being treated?
   _____
2. Have you had any serious illness or operation? Yes ❑ No ❑
   (a) If so, what is the illness or operation?
   _____
3. Have you ever been hospitalized? Yes ❑ No ❑
   (a) If so, what was the problem?
   _____
4. Are you taking any drug or medicine? Yes ❑ No ❑
   (a) If so, what?
   _____
5. Are you allergic or have you reacted adversely to any drug or medicine: e.g. local anesthetic; Penicillin or other antibiotics; barbiturates, sedatives, analgesics (pain killers)? Yes ❑ No ❑
6. Do you have or have you had any of the following diseases or problems:
   (a) Rheumatic fever or rheumatic heart disease? Yes ❑ No ❑
   (b) Congenital heart lesions? Yes ❑ No ❑
   (c) Cardiovascular disease: e.g. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke? Yes ❑ No ❑
   (d) Chest pains or shortness of breath? Yes ❑ No ❑
   (e) Asthma, hay fever, skin rash? Yes ❑ No ❑
   (f) Fainting spells or seizures: e.g. epilepsy? Yes ❑ No ❑
   (g) Diabetes? Yes ❑ No ❑
   (h) Kidney Disease? Yes ❑ No ❑
   (i) Hepatitis, jaundice or liver disease? Yes ❑ No ❑
   (j) Endocrine disorder: e.g. thyroid disease? Yes ❑ No ❑
   (k) Lung or breathing disorders: e.g. tuberculosis? Yes ❑ No ❑
   (l) Gastrointestinal disease: e.g. ulcers? Yes ❑ No ❑
   (m) Nervous disorder? Yes ❑ No ❑
   (n) Bone, muscle or joint disorders: e.g. arthritis? Yes ❑ No ❑
   (o) Cancer? Yes ❑ No ❑
7. Have you ever had abnormal bleeding associated with previous extractions. surgery or trauma? Yes ❑ No ❑
   (a) Do you bruise easily? Yes ❑ No ❑
8. Do you have any blood disorder? Yes ❑ No ❑
9. Women – Are you pregnant? Yes ❑ No ❑
10. Do you have any disease or problem not listed above you think I should know about? Yes ❑ No ❑
    (a) If so, please explain Yes ❑ No ❑
    _____
11. What dental condition concerns you at present?
    _____

Patient's Signature _____