Patient Name: _____Date_____
Last First MI
□ Male □ Female □ Married □ Single □ Child □ Other

Social Security #: _____ Birth Date: _____ E-Mail_____

Phone (Home): _____ Mobil/Cell: _____ Work: _____ Ext: _____Other_____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of Emergency: Name: _____Phone: _____ Relationship: _____

General Dentist: _____

Date of Last Dental Visit: _____ Date of last x-rays:_____

Reason for today's visit: _____

Dental Insurance Provider: _____ Member ID: _____ Group #: _____

Insurance Subscriber name: _____ Birth Date: _____

Have you ever had any of the following? Please check those that apply:

□ Anemia
□ Anticoagulants
□ Aspirin Use
□ Asthma
□ Blood Pressure High/Low
□ Cancer/Tumor
□ Diabetes, Type:
□ Dizziness/ Fainting
□ Epilepsy
□ Excessive Bleeding
□ Fosamax Use
□ Glaucoma
□ Heart Murmur
□ Heart Disease
□ HIV/AIDS
□ Hepatitis _
□ Joint Replacement
□ Liver Disease
□ Neurologic/ Phobia
□ No Epinephrine
□ Pacemaker
□ Pre Med Required
□ Pregnancy: Due_____
□ Radiation Treatment
□ Renal Disease
□ Respiratory Problems
□ Rheumatic Fever
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tobacco Usage Packs a day____
□ Thyroid
□ Tuberculosis
□ Ulcers
□ Venereal Disease
□Other:_____
_____
Allergies:
□ Antibiotic Allergy
□ Clindamycin Allergy
□ Codeine Allergy
□ Latex Allergy
□ Penicillin Allergy
□ Sulfur Allergy
□ Other Allergies_____

Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Are you now under the care of a physician? □ Yes □ No Why? _____

Name of Physician: _____Phone_____

Do you have any health problems that need further clarification? □ Yes □ No_____

Are you taking any medications, over the counter or prescribed? Please List: _____

_____

Do you pre-medicate for dental appointments? □ Yes □ No If so, why: _____

Signature_____ Date_____