Patient Information

Patient Name_____ Date _____

Date of Birth_____ Social Security #_____

Mailing Address_____

Home Phone_____ Cell Phone_____

Work Phone_____ Email Address_____

Health History

Primary Care Physician_____PCP Phone_____
Date last Seen_____Are you under the care of a Physician?_____
Have you been admitted to a hospital or needed emergency care during the past 2 years? If yes please explain_____

Please list any medications you are currently taking_____

Please list any medications you are allergic to_____

Please list any known allergies_____

Have you ever had any of the following? Please circle all that apply:

AIDS/HIV	Anemia	Arthritis	Asthma	Blood Disease
Cancer	Diabetes Type 1	Diabetes Type 2	Epilepsy	Head Injuries
Excessive Bleeding	Fainting	Glaucoma	Hay Fever	Jaundice
Heart Disease	Heart Murmur	Hepatitis B/C	High Blood Pressure	Radiation Treatment
Kidney Disease	Liver Disease	Mental Disorders	Metal/Latex Allergy	Respiratory Problems
Rheumatic Fever	Sinus Problems	Stomach Problems	Stroke	Tuberculosis
Tumors	Ulcers	Other	Anxiety	

Have you had orthopedic total joint (hip, knee, elbow, finger) replacement?_____If yes, when was this operation done?_____

Have you ever been told by a physician that you need to take an antibiotic before a dental appointment?_____If yes what medication were you prescribed?_____

Are you pregnant?_____If yes, what is your due date?_____
Are you nursing?_____

Do you smoke or chew
tobacco?_____

Do you currently use controlled substances
(drugs)?_____

Dental History

Date of last dental visit?_____

Do you brush on a daily basis?_____Do you floss on a daily basis?_____

Have you ever had complications following dental treatment?_____

Are you having pain or discomfort at this time?_____

Are you nervous or apprehensive about your dental treatment?_____

Are you unhappy with the appearance of your teeth?_____

Have you ever had an unusual reaction to dental anesthetic?_____

May we ask how you heard about our office?_____

I certify that the answers to these health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

_____

Sign Print Date