

Patient Information

Today's Date: _____

Patient Name: _____

Preferred Name: _____

Patient Address: _____

Male Female

City: _____ State: _____ Zip Code: _____

Married Single Child Other

Patient Date of Birth: ____/____/____

Patient Social Security #: ____/____/____

Home #: (____) _____ **Work #:** (____) _____ **Pager/Cell:** (____) _____

Email address: _____

Would you like to receive appointment reminders or online only special offers via email? YES / NO

Are you over the age of 18? YES / NO

If Yes, are you a full-time Student? Yes / No

If you are a full-time student, and have dental insurance benefits, please provide a copy of your school schedule for insurance purposes.

(To protect your privacy, we do not share this information outside of our company.)

Patient Employer: _____

Occupation: _____

Whom may we thank for referring you to our practice? _____

In case of an emergency, whom shall we call?

Name: _____ **Relationship:** _____ **Phone #:** _____

Health History

Do you have or have you ever had any of the following? Please check ALL that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | |

Are you allergic to any of the following?

- | | | | |
|--------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Anesthetic |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other _____ |

WOMEN: Are you pregnant? YES NO

If yes, expected due date: ____/____/____

