

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Mi  
 Male  Female  Married  Single  Child  Other  
 Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Employer Name: \_\_\_\_\_  
 Responsible Party Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Dental Insurance  Yes  No  
Street  
 \_\_\_\_\_  
City State Zip Code Driver's License #: \_\_\_\_\_

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due Date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

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

If yes, please explain: \_\_\_\_\_

Medication: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

**If I have Dental Insurance I will be responsible for any amount left unpaid.**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Consent for Services \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient, parent or guardian

### Referral Information

Whom may we thank for referring you to our practice?