Patient Information

Patient Name: ______________________ Date: __________

Preferred Nickname: ______________ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child

Social Security #: ______________ Birth Date: ______________

Phone(Home): __________(Work): __________Ext: ______Best Time to call: __________

Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time ❑M ❑T ❑W ❑T ❑F

Address: ____
Street Apt. #

____
City State Zip Code

Email Address: (optional) ______________________________

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________

Do you have or have ever had any of the following? Please check yes or no:

Yes No
❑ ❑ **AIDS/HIV**
❑ ❑ Allergies ________
____
❑ ❑ Anemia/Leukemia
❑ ❑ Arthritis
❑ ❑ **Artificial Joints**
❑ ❑ **Asthma**
❑ ❑ Blood Disease
❑ ❑ Blood Transfusion
❑ ❑ Cancer
❑ ❑ Diabetes
❑ ❑ Dizziness
❑ ❑ Epilepsy/Seizures
❑ ❑ Emotional Disturbance

Yes No
❑ ❑ Excessive Bleeding
❑ ❑ Fainting
❑ ❑ Glaucoma
❑ ❑ Growths
❑ ❑ Hay Fever
❑ ❑ Head Injuries
❑ ❑ **Heart Disease/Attack**
❑ ❑ **Heart Murmur**
❑ ❑ **Heart Prosthesis**
❑ ❑ **Heart Valve Disorder**
❑ ❑ **Hemophilia**
❑ ❑ **Hepatitis A, B or C**
❑ ❑ **High Blood Pressure**
❑ ❑ Jaundice

Yes No
❑ ❑ Kidney Disease
❑ ❑ Latex Allergy
❑ ❑ Limited use of Arm/Leg
❑ ❑ Liver Disease
❑ ❑ Mental Disorders
❑ ❑ Nervous Disorders
❑ ❑ **Pacemaker**
❑ ❑ Currently Pregnant
Due Date: ________
❑ ❑ Radiation Treatment
❑ ❑ Reaction to Anesthetic
❑ ❑ Respiratory Problems
❑ ❑ **Rheumatic Fever**
❑ ❑ Rheumatism

Yes No
❑ ❑ Sickle Cell Disease
❑ ❑ Sinus Problems
❑ ❑ Stomach Problems
❑ ❑ Stroke
❑ ❑ Tuberculosis
❑ ❑ Tumors
❑ ❑ Ulcers
❑ ❑ Venereal Disease
❑ ❑ Weight Reduction and/or Program
❑ ❑ **Codeine Allergy**
❑ ❑ **Penicillin Allergy**
Other:
❑ ________________

- Are you currently taking any medications either prescription or over the counter. ❑Yes ❑No If yes, please list:
____
- Have you ever had an injury to your mouth, teeth, or jaw. ❑Yes ❑No If yes, please explain: ________
____
- 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
If yes, please explain: ______________________________
- Name of Physician: ______________________Phone: ______________
- Do you smoke or use smokeless tobacco? ❑Yes ❑No If yes, how often: ______________
- Do you have any health problems that need further clarification? ❑Yes ❑No If yes, please explain:
____
- Are you happy with the appearance of your smile? ❑Yes ❑No

* 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.

______________________________ Date: ______________
Signature of patient, parent or guardian

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative
❑ Dental Office ❑ Yellow Pages ❑ School ❑ Work ❑ Hampton's Market ❑ Neighborhood Source ❑ Sign
Name of person or office referring you to our practice: ______________________________