

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Phone _____

Cell Phone _____ CT Lic. # _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Dental History

Previous Dentist _____ Date of last dental care _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check () if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic/Scarlet fever | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory problems | | | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | | | |

List medications you are taking, if any:

List drug allergies, if any:

