Patient Information and Health History

Patient Name: _____ Date: _____
Last, First M (Preferred Name)

Gender: M / F Family Status: S / M / D / W

Social Security #: ***(new pt's only)***_____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____(Cell): _____

Preferred confirmation type: ☐ Phone ☐ Text ☐ E-mail E-mail address_____@_____

Address: ***(SAME)*** _____Apartment #_____

_____
City State Zip Code

Health Information

New Patient's only: Date of last dental _____Reason for visit:_____

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

☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Immune System Problems
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Nervous Disorders
☐ Pacemaker
☐ **PREGNANCY**
Due date:_____
☐ Radiation / Chemotherapy
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Snoring / Sleep Apnea
☐ Stroke
☐ Thyroid Trouble
☐ Tumors
☐ Ulcers
☐ Sulfite Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Please list current medications:_____
_____
_____

- Are you **allergic** to any medications? ☐ Yes ☐ No If yes please list medication(s):_____

- Are you taking any bone density medications? (Bisphosphonates: Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva)
- ☐ Yes ☐ No please list_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
_____

- Are you currently under a physician's immediate care for major medical reasons? ☐ Yes ☐ No
If yes to either question, please explain: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

- Name of Physician: _____ Phone: _____

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