Patient Information

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

Birth Date: _____ Employer: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Co._____ Policy number:_____

Subscriber:_____ Group number:_____

Health Information

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

- ☐ HIV Positive
- ☐ Allergies _____
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Growths
- ☐ Head Injuries
- ☐ Heart Attack Date:_____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ MRSA-Methicillin Resistant Staph. Aureus
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Sulfa Allergy
- ☐ Penicillin Allergy
- ☐ VRSA-Vancomycin Resistant Staph. Aureus

Have you ever taken:

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Zometa

- List any medications you are taking:_____

_____

- 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 have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you traveled outside the USA in the last 12 months?_____

  If yes, when & where have you traveled? _____

  Do you have any reason to believe you may have been exposed to the Ebola Virus? _____

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

email address: