

Patient's Number: _____ Birth date: _____ Age: _____

Patient's Name: _____ Sex: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ SSN: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ SSN: _____

TO BE COMPLETED IF PATIENT IS A CHILD:

Patient's nickname: _____

Father's Name: _____

Marital Status: M D S

Address: _____

Home Number: _____

Employer: _____

Work Number: _____

Father's Insurance Company: _____

Father's SS#: _____

Father's Date of Birth: _____

Mother's Name: _____

Marital Status: M D S

Address: _____

Home Number: _____

Employer: _____

Work Number: _____

Mother's Insurance Company: _____

Mother's SS#: _____

Mother's Date of Birth: _____

Have we treated other children in the family? Yes No

If so who _____

Family Dentist: _____

Family Physician: _____

Who referred you to us? _____

Patient Number:

Medical History:

Your current health is: Good Fair Poor

Are you currently under the care of a physician? No Yes

Are you currently taking any prescription/over-the-counter drugs? No Yes

If yes, please list _____

For Women:

Are you taking birth control pills? No Yes

Are you pregnant? No Yes

Are you nursing? No Yes

At what age did patient start her menstrual period? _____

Have you ever had any of the following Diseases or Medical Problems?

- | | | | |
|-----|----------------------------|-----|-------------------------------|
| Y N | Heart Attack/Stroke | Y N | Psychiatric Problems |
| Y N | Cancer/ Chemotherapy | Y N | Epilepsy/ Seizures/ Fainting |
| Y N | Heart Murmur | Y N | Diabetes/ Tuberculosis (TB) |
| Y N | Rheumatic Fever | Y N | Drug/ Alcohol Abuse |
| Y N | HIV+/ AIDS | Y N | Veneral Disease |
| Y N | Heart Surgery/ Pacemaker | Y N | Hemophilia/ Abnormal Bleeding |
| Y N | Shingles | Y N | Ulcers/ Colitis |
| Y N | Mitral Valve Prolapse | Y N | Congenital Heart Defect |
| Y N | Kidney Problems | Y N | Anemia/ Radiation Treatment |
| Y N | Artificial Bones/Joints | Y N | Asthma / Arthritis |
| Y N | Artificial Valves | Y N | Difficulty Breathing |
| Y N | Sinus Problems | Y N | Hospitalized for any reason |
| Y N | High/Low Blood Pressure | Y N | Hepatitis |
| Y N | Fever Blisters | Y N | Blood Transfusions |
| Y N | Severe/ Frequent Headaches | Y N | Emphysema/ Glaucoma |

Please list any serious medical condition (s) that you have ever had: _____

- Have you ever had your Tonsils or Adenoids removed? Y N What age? _____
- Have you ever had Speech Therapy? Y N What age? _____
- Do you play a Musical Instrument? Y N What Instrument? _____
- Did you ever have a Thumb/ Finger Habit? Y N Stopped at what age? _____

Are you allergic to any of the following?

- | | | | | | |
|-----|--------------|-----|--------------------|-----|-------|
| Y N | Penicillin | Y N | Tetracycline | Y N | Latex |
| Y N | Aspirin | Y N | Dental Anesthetics | Y N | Other |
| Y N | Erythromycin | Y N | Codeine | | |

Please List any other Allergies: _____

Are you required to be premedicated for dental procedures? NO YES

Signature

Date