PATIENT INFORMATION FORM

PATIENT'S NAME (First)________________________(MI) ______ (Last)______________________________________
PATIENT'S SS#____ Date of Birth ____________________________
ADDRESS ____
____ ZIP ______________________________________
TELEPHONE (Home) ____ (Work) ______________________________
Full time student? ☐ yes If yes, where? ______________________ #credit hrs taking _____ expected grad. yr. ______
Address: (City) ____ (State)____________________ Zip ___________

PATIENT'S EMPLOYER ____
EMPLOYER'S ADDRESS ____
If married, spouse's name____
If minor, parent's name____
Emergency contact name ________________________ Relationship__________________ phone #__________________

Responsible Party ____ Responsible Party's SS# ____________________
Address if different from patient ____
Responsible Party's Employer ____
Responsible Party's Employer's Address ____
What is the reason for your visit today? ____
Who referred you to this office? ____

MEDICAL INFORMATION: Do you have, or have you ever received treatment for, the following conditions?

	Yes	No		Yes	No		Yes	No
Rheumatic fever	☐	☐	Diabetes	☐	☐	Hepatitis (liver disease)	☐	☐
Heart Disease	☐	☐	Epilepsy	☐	☐	Prolonged Bleeding	☐	☐
High Blood Pressure	☐	☐	Severe Asthma	☐	☐	TMJ (Jaw joint) Problems	☐	☐
Heart Murmur	☐	☐	AIDS/HIV	☐	☐	Now Pregnant _____ # months	☐	☐
Pacemaker/Defibrillator	☐	☐	Joint Replacement	☐	☐	Psychologic/Neurologic disorders	☐	☐
Replacement Heart Valve	☐	☐	Sleep apnea	☐	☐	Cancer/ Treatment	☐	☐

List Other Medical Conditions:____

List ALL medications you take or have taken to treat or prevent osteoporosis ______________________________
____
List ALL medications you take:____
____
____
Reason for your last visit to your physician____
Have you ever had a general anesthetic? ☐ yes ☐ no
Did you ever have an unfavorable reaction to general anesthesia? ☐ yes ☐ no Local anesthesia? ☐ yes ☐ no
If yes, please describe ____
Have you ever had a problem with previous dental treatment? ☐ yes ☐ no
If yes, please explain____

Are you allergic to penicillin? ☐ yes ☐ no Latex? ☐ yes ☐ no Allergic to any other drugs? ☐ yes ☐ no
If yes, what drugs? ____
____
Name of your family physician (M.D./D.O.): ____
Name of your family dentist (D.D.S./D.M.D.): ____
Have you had anything to eat or drink within the last 5 to 6 hours? ☐ yes ☐ no

Are you wearing contact lenses? ☐ yes ☐ no
Do you smoke? ☐ yes ☐ no If yes, how much? ______________________

The above medical history I have given is complete and correct to the best of my knowledge.

Date ______________________

Signature ____________________________________

Reviewed by	Patient	Date