Chart #: ____________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________________ Date: __________
Last First MI (Preferred Name)

Gender: __________ Family Status: __________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): __________ Ext: ______ (Cell) __________

Email Address ____

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for this visit: ____________________

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

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies __________	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
__________	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ Pregnancy	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date: __________	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ __________
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ __________
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

- 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: ____

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

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other __________

Name of person or office referring you to our practice: ____________________