***Welcome to our office!*** **To help us provide the best comprehensive care for you, please answer the following questions as accurately as possible. PLEASE PRINT!**

PATIENT'S NAME_____SEX_____DATE OF BIRTH_____

(Please Circle) CHILD SINGLE MARRIED DIVORCED WIDOWED COLLEGE STUDENT

IF CHILD, PARENT'S NAME_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____EMPLOYER_____

CELL PHONE_____E-MAIL (H)_____E-MAIL (W)_____

JOB TITLE_____BUSINESS ADDRESS_____

DRIVER'S LICENSE#_____SOCIAL SECURITY#_____

NAME OF RELATIVE NOT LIVING WITH YOU:_____PHONE#_____

ADDRESS_____CITY_____STATE_____ZIP_____

PLEASE CIRCLE METHOD OF PAYMENT: CASH CHECK CREDIT CARD (Visa, Mastercard, Discover, Am Ex, Care Credit)

## ----------REFERRAL INFORMATION----------

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

(Please Circle) Dental office Phone Book Neighborhood Newspaper School Work Church Drive by Insurance

Other:_____

_____

## ----------MEDICAL HISTORY----------

DATE OF LAST DENTAL EXAM/X-RAY_____PREVIOUS DENTIST_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please circle: Y=Yes, N=No) Y N Pregnant (due date)_____

| | | | |
|---|---|---|---|
| Y N Rheumatic Fever | Y N Artificial Joint | Y N Abnormal Bleeding | Y N Lung Problems/Asthma |
| Y N Heart Problems | Y N Latex Allergy | Y N Tobacco Usage | Y N Hepatitis |
| Y N High Blood Pressure | Y N Aids/HIV Positive | Y N Fainting/Seizures | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Cancer | Y N Ulcers/Stomach Problems | Y N Tuberculosis |
| Y N Heart Murmur | Y N Radiation Treatment | Y N Angina | Y N Alzheimers |

ARE YOU ALLERGIC TO ANY MEDICATION? (Please circle) YES NO If YES, please explain:_____

_____

HAVE YOU EVER BEEN TOLD YOU NEED TO BE PRE-MEDICATED FOR DENTAL TREATMENT? (Please circle) YES NO

NAME OF PHYSICIAN_____DATE OF LAST EXAM_____PHONE_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING_____

_____

HAVE YOU EVER HAD A REACTION TO LOCAL ANESTHESIA?_____WHEN?_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of patient, parent, or guardian Date