PATIENT HISTORY AND INFORMATION

-PLEASE PRINT-

Patient Name: _____ Date of Birth _____

Current Address _____ City _____State _____ Zip _____

☐ Home Phone _____ ☐Work Phone _____

☐ Cell Phone_____ Email: _____ _____

Please Check Preferred Contact Number

Whom can we thank for referring you? _____

1. Are you under the care of a physician at the present time? _____

A. If so, what is the condition being treated? _____

B. Please list ALL medication NOW being taken. 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ _ 7. _____ 8. _____ 9. _____

2. Physician Name and Phone number _____Pharmacy Name and Phone Number_____

3. Are you allergic or have sensitivity to any of the following:

Yes No		Yes No		Yes No		Yes No	
__ __	Penicillin	__ __	Aspirin	__ __	Nitrous Oxide	__ __	Other _____
__ __	Sulfa	__ __	Erythromycin	__ __	Local Anesthetic		
__ __	Codeine	__ __	Iodine	__ __	Dental Materials		

4. Please list antibiotic IF premedication needed _____

5. Check any of the following which you have or have had:

__Heart Disease or Attack
__Angina Pectoris
__High Blood Pressure
__Low Blood Pressure
__Heart Murmur
__Rheumatic Fever
__Prolapse Mitral Valve
__Congenital Heart Lesions
__Scarlet Fever
__Artificial Heart Valve
__Heart Pacemaker
__Heart Surgery
__Artificial Joint

__Anemia
__Stroke
__Kidney Trouble
__Ulcers or Stomach Problems
__Emphysema
__Cough
__Tuberculosis (TB)
__Asthma
__Hay Fever
__Sinus Trouble
__Allergies
__Diabetes
__Thyroid Disease

__X-ray or Cobalt Treatment
__Chemotherapy (Cancer, Leukemia)
__Arthritis or Rheumatism
__Cortisone Medicine
__Glaucoma
__Pain in Jaw Joints
__Tumors or Malignancies
__AIDS
__Hepatitis A (infectious)
__Hepatitis B (Serum)
__Hepatitis C
__Liver Disease
__Yellow Jaundice

__Blood Transfusion or Disease
__Drug Addiction
__Hemophilia
__Venereal Disease (Syphilis, Gonorrhea)
__Cold Sores
__Genital Herpes
__Epilepsy or Seizures
__Fainting or Dizzy Spells
__Nervousness
__Psychiatric Treatment
__Sickle Cell Disease
__Bruise easily or Heal Slowly
__HIV Positive

6. Are there any other medical problems, conditions, or diseases not mentioned above that we should be aware of? _____

WOMEN: Are you pregnant now? _____Are you nursing? _____ _

Do you have a history of miscarriage? _____ Do you take any hormones or birth control pills? _____ _

PARENT: If there is a need: May we use local anesthetic on your child? _____ _

ALL PATIENTS: -In case of Emergency call:_____Phone Number:_____

Signature:_____ Date: _____

Relationship to Patient (if signing for someone other than yourself) _____

(CONFIDENTIAL INFORMATION FOR OUR FILES)