Patient Information

Date_____ **Patient name** _____

SS#: _____ **DOB** _____ **Married**___ **Single**___ **Male** ___ **Female** ___

Home# _____ **Work#**_____ **Cell#**_____

Address _____

City _____ **State** _____ **Zip Code** _____

Email Address: _____

Person to contact in case of an emergency? _____

Health Information

Date of Last Dental Last Visit: _____ **Reason For This Visit:** _____

Check if you have or had any of the following:

	Artificial Heart Valves		Heart Problems
	Artificial Joints		Hepatitis
	Asthma		High Blood Pressure
	Bisphosphonates		Kidney Disease
	Blood Thinners		Liver Disease
	Cancer		Mitral Valve Prolapse
	Chemotherapy		Pacemaker
	Coumadin		Radiation Treatment
	Diabetes		Rheumatic fever
	Epilepsy		Thyroid Problems
	Heart Murmur		Tobacco Habit

Any allergies to the following medications:

	Clindamycin
	Penicillin
	Codeine
	Local anesthetic
	Latex

Do you have any health problems that need further clarification? (if so, please explain)-

_____

_____

(Women) Are you pregnant _____Yes _____ No

Have you ever had any complications following dental treatment? (if so, explain)

_____

Are you currently taking medications? _____

Please List _____

_____

Whom may we thank for referring you? _____

To the best of my knowledge all the information provided are true and correct. If I have any change to my health, I will inform the doctors at the next appointment.

_____

Signature of patient (or parent/guardian if minor) DATE

PLEASE GIVE US YOUR PHARMACY NAME, ADDRESS AND PHONE #

Name _____

Address _____

_____

Phone # _____