Patient Information and Health History

Please Complete Front and Back

Date_____

Dr/Mr/Mrs/Miss/Prof_____

Address_____

City/Town_____State_____Zip_____

Home Phone#_____Cell#_____

Email Address_____

Billing Address (if different)_____

City/Town_____State_____Zip_____

Employer_____

Address_____

Phone#_____Occupation_____

Date of Birth____/_____/_____ Social Security#_____-_____-_____

Marital Status Single_____Married_____Divorced_____Widowed_____

Name of Dental Insurance (if applicable)_____

Address of Insurance Company_____

_____ Phone#_____

Who is the Subscriber of your dental insurance?_____

Date of birth of Subscriber___/___/____Social Security#____-___-_____

ID#_____Group#_____

Who is responsible for this account?_____

Whom may we thank for this referral_____

Previous Dentist_____

Date of last dental examination_____

Please Continue onto Back

Name and address of physician_____

_____

Have you ever been treated for any of the following (please check if yes)

_____Heart disease _____Hepatitis

_____Abnormal blood pressure _____Liver disease

_____Stroke/cardiac arrest _____Lung disease

_____Heart murmur _____Asthma

_____Rheumatic fever _____Anemia

_____Abnormal/excessive bleeding _____Diabetes

_____Epilepsy or seizures _____Glaucoma

_____Artificial valve or joint _____Arthritis

_____Stomach or intestinal d/o _____Ulcers

_____Mitral valve prolapse _____HIV/AIDS

_____Cancer or radiation _____Pacemaker

_____Penicillin allergy _____Codeine allergy

_____Sinus/respiratory problems _____Pregnancy

_____Stroke _____Latex allergy

Other conditions (please explain)_____

_____

Please list any allergies_____

What medications are you currently taking:_____

_____ _____

_____ _____

Any medical issues we should know about?_____

_____

Signature_____

Medical HX update:
Initial/Date_____Initial/Date_____

Initial/Date_____Initial/Date_____