PATIENT INFORMATION

Patient Name:_____ **Date:**_____
Last First MI

___ Male ___ Female Married ___ Single ___ Child ___ Other ___ **Social Security #:**_____

Birth Date:_____ **Phone (Home):**_____ **(Cell):**_____

Address:_____
Street Apt# City State Zip Code

Email Address:_____ **Emergency Contact**_____**Phone:**_____

HEALTH HISTORY

Date of Last Dental Visit: _____ Reason for this Visit: _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ___Yes ___No

Have you ever had any of the following:

__ Joint Replacement /Date:	__ High Blood Pressure	__ Diabetes __Type I __ Type II
Describe:	__ Pacemaker	__ Tuberculosis
__ Artificial Heart Valve	__ Rheumatic Fever	__ Thyroid Disease
__ Previous Infective Endocarditis	__ Stroke	__ Hepatitis or Liver Disease
__ *Congenital* Heart Disease (unrepaired or recent repair)	__ Abnormal Bleeding	__ Kidney problems
__ Damaged Valves in Transplanted Heart	__ Hemophilia	__ Epilepsy
__ Cardiovascular Disease	__ Anemia	__ Fainting Spells or Seizures
__ Angina	__ Arthritis	__ AIDS or HIV Infection
__ Arteriosclerosis	__ Autoimmune Disease	__ Cancer __ Chemotherapy
__ Congestive Heart Failure	__ Asthma	__ Growths / Tumors
__ Damaged Heart Valve	__ COPD Chronic Obstructive Pulmonary Disease	__ Osteoporosis
__ Heart Attack	__ Sinus Trouble	__ Neurological Disorders
__ Mitral Valve Prolapse	__ Gastrointestinal Disease	__ Sleep Disorder
__ Heart Murmur	__ GERD / Reflux / Heartburn	__ Mental Health Disorder
__ Low Blood Pressure	__ Eating Disorder	__ Chronic Pain

Do you smoke? __ Yes __ No # of years? ____ Do you chew tobacco? __ Yes __ No

Do you have any disease, condition, or problem not listed above that you think we should know about? ___ Yes ___ No

Explain: _____

Have you been admitted to the hospital during the past two years? ___ Yes ___ No

Explain: _____

Physician Name: _____ Address: _____ Phone # _____

Pharmacy Name: _____ Address: _____ Phone # _____

Current Medications Dosage Reason for Taking	Are you **ALLERGIC** to or had a reaction to the following	
1	Local Anesthetic	Yes
2	Penicillin	Yes
3	Sulfa	Yes
4	Codeine (or other narcotics)	Yes
5	Aspirin	Yes
6	Other:	

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature (patient, parent, guardian):_____ Date: _____

Doctor Signature: _____ Date: _____