Patient Information And Health History

Name_____ Date Of Birth_____

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

Address_____Phone_____

Person Responsible For This Account_____Phone_____

Address_____

Employed By_____Business Phone_____

Dental Insurance_____Patient's SS#_____

Group ID #_____Referred By_____

Chief Oral Complaint_____

Yes	No	Does Your Medical History Include Any Of The Following:
____	_____	Allergies to Anesthetics
_____	_____	Allergies to any Medications
_____	_____	Any Heart Ailments/Heart Murmur
_____	_____	Rheumatic Fever
_____	_____	High Or Low Blood Pressure
_____	_____	Neurological Disorders
_____	_____	Radiation Treatment
_____	_____	Excessive Bleeding From Cut Or Extraction
_____	_____	Anemia Or Blood Problems
_____	_____	Arthritis
_____	_____	Asthma
_____	_____	Hay Fever Or Allergies In General
_____	_____	Diabetes /Kidney Problems
_____	_____	Liver Problems or Hepatitis
_____	_____	Malignancies
_____	_____	Psychiatric Care
_____	_____	Sinus Problems
_____	_____	Stroke
_____	_____	Thyroid
_____	_____	Eye Disorder
_____	_____	Tonsillitis
_____	_____	Tuberculosis
_____	_____	Ulcer Or Colitis
_____	_____	Pregnancy- If So What Month_____
_____	_____	Venereal Disease
_____	_____	Acquired Immune Deficiency Syndrome (AIDS)
_____	_____	Any Other Medical Conditions_____

List Any Drugs or Medications You are Currently Taking_____

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In Case Of Emergency, Notify_____ Phone #_____

Patient Signature_____ Date_____