

Chart#: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name _____ Date: _____
Last First M (Preferred Name)
Gender: _____ Family Status: _____
Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone #: _____
Address: _____ Email: _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____
Have you ever had any of the following? Please check those that apply:
 AIDS Excessive Bleeding Liver Disease Stroke
 Allergies _____ Fainting Mental Disorders Tuberculosis
 Anemia Glaucoma Nervous Disorders Tumors
 Arthritis Growths Pacemaker Ulcers
 Artificial Joints Hay Fever Pregnancy Venereal Disease
 Asthma Head Injuries Due date: _____ Codeine Allergy
 Blood Disease Heart Disease Radiation Treatment Penicillin Allergy
 Cancer Heart Murmur Respiratory Problems OTHER: Current Meds:
 Diabetes Hepatitis Rheumatic Fever _____
 Dizziness High Blood Pressure Rheumatism _____
 Epilepsy Jaundice Sinus Problems _____
 Kidney Disease Stomach Problems

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____