

Date _____

Patient Information

Patient Name _____

Address _____ (last) _____ (first) _____ (middle)
City _____ State _____ Zip _____

Phone _____ Sex _____ Age _____ DOB _____ SSN: _____

Employer _____ Work Phone _____ Marital Status: S M D W (circle one)

Insurance Subscriber _____ Relationship _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone _____ Employer _____ Work Phone _____

Primary Dental Insurance _____ ID#/Subscriber SSN _____ Group# _____

Secondary Dental Insurance _____ ID#/Subscriber SSN _____ Group# _____

Referring Dentist/Doctor _____ Phone _____

Current Medications _____

Hospital Admissions (Reason & Date) _____

Present Medical Problems _____

Medication Allergies _____

Check any of the following that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rash/Hives | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia | <input type="checkbox"/> MVP |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Excess Bleeding | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Easily Bruised | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Faintness |
| <input type="checkbox"/> Hepatitis if so, type _____ | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other _____ | | |

Describe any of the above that apply _____

Do you smoke? Y N If YES, how much per day? _____ Drink Alcohol? Y N If YES, frequency? _____
(circle one) (circle one)

Have you ever had an unfavorable reaction to Local/General Anesthesia? Y N If so, describe _____
(circle one)

Patient Signature/Parent of Minor/Legal Representative

Date