{Patient Information} Date_____

Patient Name_____
(first) (last) (middle)

Address_____City_____State_____Zip_____

Phone_____ Sex_____ Age_____ DOB_____ SSN:_____

Employer_____ Pharmacy Name/Number_____ Marital Status: S M W D
(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:

[ ] Rheumatic Fever
[ ] Kidney Disease
[ ] Heart Attack
[ ] Liver Disease
[ ] Jaundice
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Tuberculosis
[ ] Hepatitis if so, type____
[ ] Joint Replacement
[ ] Fever
[ ] Heart Surgery
[ ] Other _____

[ ] Wheezing
[ ] Rash/Hives
[ ] Anemia
[ ] Excess Bleeding
[ ] Easily Bruised
[ ] Dizziness
[ ] Nose Bleeds
[ ] Sore Throat
[ ] Hoarseness
[ ] Sinusitis
[ ] Shortness of Breath
[ ] Stroke

[ ] Chest Pain
[ ] HIV
[ ] MVP
[ ] Heart Murmur
[ ] Swelling of Feet
[ ] Palpitations
[ ] Asthma
[ ] Faintness
[ ] Pregnant
[ ] Diabetes
[ ] Sleep Apnea
[ ] Cancer

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)

Email _____

_____ _____
Patient Signature/Parent of Minor/Legal Representative Date