Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

SS#/SIN: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Email: _____

Address: _____
Street Apartment #

_____
City State/Province Zip/Postal Code

Referred By: _____

In Case of Emergency: _____
Name Relationship Phone

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- Hepatitis A, B or C
- High Cholesterol
- ☐ High Blood Pressure
- ☐ Thyroid
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnant due date
- Jaundice
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Osteoporosis
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

☐ **Codeine Allergy**

☐ **Penicillin Allergy**

OTHER:

Allergy:

Other health issues

Medication list

_____

- 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 General 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