PATIENT

NAME last .... firs .... middle .... MALE FEMALE

DATE OF BIRTH .... SOCIAL SECURITY # .... EMAIL ....

ADDRESS .... city .... state .... zip ....

PHONE home .... work .... cell ....

EMPLOYER .... IF MINOR, PARENT'S NAME ....

REFERRED BY ....

MAIN CONCERN/REASON FOR VISIT ....

EMERGENCY

EMERGENCY CONTACT .... RELATION TO PATIENT .... PHONE ....

ADDRESS .... city .... state .... zip ....

MEDICAL INFORMATION

JOINT REPLACEMENT (HIP, KNEE, ETC.?) **Y** **N**

If yes, what joint.. when.. surgeon ....

ARE YOU A SMOKER? **Y** **N** if so, how much per day? SMOKELESS TOBACCO? **Y** **N**

HAVE YOU BEEN DIAGNOSED WITH ANY MEDICAL CONDITIONS SINCE YOUR LAST DENTAL VISIT? **Y** **N**

If yes, explain

HAVE YOU HAD ANY CARDIAC CHANGES SINCE YOUR LAST DENTAL VISIT? (Including valve replacement, endocarditis, diagnosis of congenital heart defect present from birth) **Y** **N**

ALLERGIES

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

Local Anesthetics	**Y**	**N**	Penicillin	**Y**	**N**
Codeine	**Y**	**N**	Other	**Y**	**N**

MEDICATIONS

PREFERRED PHARMACY

Please list any medications you are currently taking (Please include aspirin and/or blood thinners):

1.. 2.. 3..

4.. 5.. 6..

I understand the above information is necessary to provide me with dental care in a safe and efficient mann . I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

PRINT PATIENT'S NAME ....

PATIENT/PARENT SIGNATURE* .... DATE ....

**all electronic signatures are the legal equivalent of a manual/handwritten signature*