Patient Information

Name: ______________________________________ Date: _______________

Social Security #: ______________________________ DOB: _______________

Preferred Contact Phone #: ____

Address: ____

Cell Phone #: _______________________ Email Address: ____________________

Has Insurance Changed (Circle One) Yes / No

Have you ever had any of the following? Please check all that apply.

___ AIDS/HIV Infection
___ Allergies:_______________
___ Anemia
___ Anxiety/Mental Disorder
___ Arthritis (Type) ___________
___ Artificial Joints Date___ Type___
___ Asthma
___ Autoimmune Disease ________
___ Blood Disorder
___ Cancer Type_______ When____
___ Depression
___ Diabetes
___ Dizziness/Fainting
___ Epilepsy
___ Excessive Bleeding
___ Growths
___ Head Injuries/Headaches
___ Pre-medicate
___ Penicillin Allergy
___ Heart Murmur/ Mitral Valve Prolapse
___ Heart Problems (Type) ____________
___ Hepatitis (Type) _________________
___ High Blood Pressure
___ Kidney Disease
___ Liver Disease/ Jaundice
___ Radiation Treatment
___ Respiratory Problems
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Tumors
___ Ulcers
___ Venereal Disease
___ Pregnant Due Date ______________
___ Pacemaker
___ Other ________________________

Have you ever taken bisphosphonates for osteoporosis? YES NO

Are you allergic to Latex? YES NO

Are you currently taking blood thinners? YES NO

Current Medications: ____

Have you ever had any complications following past dental treatments? YES NO

Physician: ____________________________________ Phone: ___________________

I have reviewed and accept the terms of the Privacy Act (HIPAA)

Signature:_____________________________________ Date: ____________________