Chart # _____
FOR OFFICE USE ONLY.

Patient Information

Patient Name: _____ Date: _____

Gender _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Email Address _____

Preferred appointment times: □ Morning □ Afternoon □ Evening □ Any Time DM DT OW DT OF OS

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____

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

□ AIDS
□ Allerqies _____
_____
□ 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
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervous Disorders
□ Pacemaker
□ Pregnancy
Due date:
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Stomach Problems
□ Stroke
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□ Codeine Allergy
□ Penicillin Allergy
OTHER:
□ _____
□ _____

- 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 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

Referral Information

Whom may we thank for referring you to our practice? DAnother patient, friend DAnother patient, relative

□ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other

Name of person or office referring you to our practice: _____