PATIENT INFORMATION

Date _____ DOB _____

Name _____

Address _____

City, State, Zip _____ Cell Phone _____

Hm Phone _____ Wk Phone _____

Marital Status _____ Sex _____

SSN _____ Occupation _____

Employer _____

Name of dentist who referred you: _____

Reason for today's visit: _____

MEDICAL QUESTIONNAIRE

Name of Physician _____ Phone# _____

If you have or have had any of the following: (please check)

___ Heart Conditions
___ High Blood Pressure
___ Rheumatic Fever
___ Stroke
___ Circulatory Problems
___ Radiation Treatments
___ Malignancies
___ Gout
___ Asthma
___ Bronchitis
___ Lung Problems
___ Epilepsy
___ Arthritis
___ Hepatitis
___ Tuberculosis
___ H.I.V./ AIDS
___ Diabetes
___ Anemia
___ Excessive Bleeding
___ Ulcer
___ Liver Problems
___ Joint Replacement: hip / knee
___ Chronic Fatigue
___ Gall Bladder Conditions
___ Venereal Disease/Herpes
___ Shortness of Breath
___ Kidney Problems
___ Dizziness
___ Fainting
___ Depression/ Anxiety
___ Psychiatric Conditions
___ Pregnant (currently)

If checked YES to any question, please explain: _____

_____

Please list any **allergies** to medications: _____

Please list all medications that you take on a regular basis: _____

_____

Are you required to premedicate with antibiotic prior to dental treatment? _____

Any additional information that you feel might be important: _____

_____

I have completed this form to the best of my knowledge

_____

Patient's/Guardian's Signature