Print Form

# PATIENT INFORMATION AND HEALTH PROFILE

Patient Name _____ Date ____/____/____

Date of Birth ____/____/____ Name of Parents if Child _____

Address _____

Telephone: Home _____ Cell _____ Workplace _____

E-mail Address _____ May we use it to contact you? ____

Occupation _____ Social Security # _____

Employer _____ If married, spouse's name _____

Emergency Contact _____ Telephone _____

**Please check any medical problems that you had or currently have:**

| | | |
|---|---|---|
| ☐ Asthma | ☐ Arthritis | ☐ Prosthetic Joint |
| ☐ Anemia | ☐ Kidney Disease | ☐ Angina |
| ☐ Diabetes | ☐ Substance Abuse | ☐ Pacemaker |
| ☐ Cancer | ☐ Immune System Disorder | ☐ High Blood Pressure |
| ☐ Epilepsy | ☐ Thyroid Problems | ☐ Heart Valve Prolapse |
| ☐ Hepatitis | ☐ Bleeding Disorder | ☐ Coronary Artery Disease |
| ☐ Sinusitis (Chronic) | ☐ Fainting or Dizziness | ☐ Artificial Heart Valve |
| ☐ Anxiety/Depression | ☐ Pulmonary Disease | ☐ Stroke |

**Also:**

Have you had any surgical procedures or hospitalizations in the last five (5) years? _____

Are you sensitive to Penicillin? ____ Other medications? _____ Latex? ____ Anything else? _____

Women, are you now pregnant or hope to be soon? _____ Nursing? _____

Your Physician _____ Telephone _____

Any medical problem you are currently being treated for? _____

Are you taking any blood thinners or are you on aspirin therapy? _____

Have you ever been treated for osteoporosis? ____ If so, with what medication? _____

List all medications you are taking _____ _____

_____ _____

_____ _____

***Please continue on the next page***

Have you ever had to pre-medicate for a dental appointment? _____

Do you feel especially fearful about dental treatment? _____

In the past, have you had any special problems with your teeth? _____

_____

## THANK YOU.

Our entire team is committed to providing our patients with excellent dental care and professional service.
Keeping us informed about your medical health and the feelings you have about dental treatment is critical.

Who may we thank for referring you? _____

Please sign _____

For your next few visits :

## UPDATES

PLEASE INITIAL ☐

Date ___/___/_____ Changes: _____ BP _____

Date ___/___/_____ Changes: _____ BP _____

Date ___/___/_____ Changes: _____ BP _____

Date ___/___/_____ Changes: _____ BP _____

Date ___/___/_____ Changes: _____ BP _____