# Patient Information

## Personal

| | |
|---|---|
| Name (First, Last): | |
| Preferred Name: | |
| Full Mailing Address: | |
| Home Phone: | |
| Business Phone: | |
| Cell Phone: | |
| Email Address: | |
| Date of Birth: | |
| Sex: | |
| How did you hear about our office? | |

## Medical

| | |
|---|---|
| Family Doctor & ph # if known: | |
| Emergency contact & ph #: | |
| Please list any current illnesses/diseases/disorders: | |
| Please List any Allergies: | |
| Current medications: | |
| Please list any herbals you take: | |

**Do you have or have you had the following:**

**Additional information for “Yes” in this space:**

| | | |
|---|---|---|
| AIDS/HIV | Yes ☐ | No☐ |
| Hepatitis A, B, C | Yes ☐ | No☐ |
| Heart Surgery | Yes ☐ | No☐ |
| Heart Attack | Yes ☐ | No☐ |
| Congenital Heart Defects | Yes ☐ | No☐ |
| Infective endocarditis | Yes ☐ | No☐ |
| Stroke | Yes ☐ | No☐ |
| High/Low Blood Pressure | Yes ☐ | No☐ |
| Blood Disorders | Yes ☐ | No☐ |
| Do you bleed easily? | Yes ☐ | No☐ |
| COPD | Yes ☐ | No☐ |
| Asthma | Yes ☐ | No☐ |
| Diabetes | Yes ☐ | No☐ |
| Herpes | Yes ☐ | No☐ |
| Methemoglobinemia | Yes ☐ | No☐ |
| Reaction to anesthetics | Yes ☐ | No☐ |
| Mental/Nervous Disorder | Yes ☐ | No☐ |
| Cancer | Yes ☐ | No☐ |
| Radiation treatment | Yes ☐ | No☐ |
| Epilepsy or seizures | Yes ☐ | No☐ |
| Osteoporosis | Yes ☐ | No☐ |
| Do you smoke or vape? | Yes ☐ | No☐ |
| Do you use recreational drugs? | Yes ☐ | No☐ |
| Are you pregnant or breastfeeding? | Yes ☐ | No☐ |

Please list or notify staff of any other health concerns you believe may be important:

## Dental

| What concerns do you have with your teeth/mouth? | |
|---|---|
| How long since your last dental visit? | |
| How often do you brush? | |
| How often do you floss? | |

**Please answer the following:**

**Additional information for "Yes" in this space:**

| | | |
|---|---|---|
| Do you clench or grind? | Yes ☐ | No☐ |
| Do you have jaw joint issues? | Yes ☐ | No☐ |
| Have you had braces/Invisalign? | Yes ☐ | No☐ |
| Do your gums bleed easily? | Yes ☐ | No☐ |
| Do you have sensitive teeth? | Yes ☐ | No☐ |
| Do you catch food in your teeth? | Yes ☐ | No☐ |
| Are you happy with your smile? | Yes ☐ | No☐ |

Please note or tell staff of any other dental information you believe may be important:

**General release:**

I verify the above information is accurate and complete to the best of my knowledge and have not knowingly omitted any information. Should there be any changes to the health information I have provided, I will advise this dental office. I authorize the dental staff to employ diagnostic/therapeutic aids they deem necessary, in order to provide appropriate dental care. I understand that responsibility for payment of dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Signature ______________ Printed Name ______________ Date ______________