PATIENT INFORMATION AND HEALTH HISTORY

Patient's Name _____ Date of birth _____

If patient is a child, Parents name? _____

THE FOLLOWING INFORMATION IS ESENTIAL FOR THIS OFFICE TO PROVIDE DENTAL CARE IN A MANNER THAT IS COMPATABILE WITH YOUR GENERAL HEALTH. YOUR COOPERATION IN PROVIDING ACCURATE INFORMATION IS NECESSARY TO MEET YOUR DENTAL NEEDS SAFELY AND EFFICIENTLY. INCORRECT INFORMATION CAN BE DANGEROUS TO YOUR HEALTH.

WARNING: ANESTHETICS AND OTHER MEDICATIONS MAY INTERACT WITH PRESCRIPTIONS OR OVER-THE-COUNTER DRUGS. THESE INTERACTIONS MAY BE SERIOUS, YOU MUST INFORM THE OFFICE OF ALL DRUGS AND MEDICATIONS YOU ARE TAKING, YOU MUST ALSO DISCLOSE IF YOU ARE A RECOVERING ALCOHOLIC OR DRUG ABUSER.ALL INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE. TO OUR FEMALE PATIENTS, SOME ANTIBIOTICS MAY INTERFERE IN THE EFFECTIVENESS OF BIRTH CONTROL.

Name of physician _____ Phone _____
Address _____
Date and reason for last visit? _____

DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

__Heart Attack / Disease
__Heart Mumur / Angina
__Artificial Heart Valves
__Diabetes
__Circulatory Problems
__High or Low Blood Pressure
__Clotting Problems
__Rheumatic Fever
__Hepatitis A/ B/ C
__Liver Disease
__Stomach Ulcers
__Lupus
__HIV Positive / AIDS
__High Fevers
__Tuberculosis (TB)
__Cough or Spit up Blood
__Surgery

__Arthritis – Osteo/Rheumatiod
__ Back Pain
__Nervous Condition
__Headaches
__Stroke-Embolism or Rupture
__Epilepsy
__Sinus Infections
__General Allergies/Hay Fever
__Psychiatric Care
__Alcoholism or Drug Abuse
__Emphysema / Asthma
__Night Sweats / Chills
__Cancer / Tumors
__Radiation / Chemotherapy
__Persistent Cough
__Loss of Weight or Appetite
__Other_____

__ I have no medical conditions_____(Signature)

(OVER)