Patient Information

Patient Name: _____ (_____) ☐ Male ☐ Female
First M. I. Last Preferred Name

Relationship to Responsible Party ☐Self ☐Spouse ☐Child ☐Other Fulltime College Student ☐

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell # _____

Address: _____
Apartment #

Emergency Contact Name Phone

Health Information

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

- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
  Insulin dependent
  Yes ☐ No ☐
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement
  Date _____.
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ **M**itral **V**alve **P**rolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Current **Pregnancy**
  Due date:_____.
- ☐ Radiation Treatment to the head or neck
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sinus Problems
- ☐ Surgical Implant
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis

Allergies

- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy

Other Allergies

_____
_____
_____
_____

List Current Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- Are you currently taking blood thinners? ☐ Yes ☐ No

  If yes, what medication are you taking? _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- If you have **Osteoporosis** were you ever given IV medication for it? When? _____

- Do you have Artificial Heart Valves or Stents? ☐ Yes ☐ No

  If yes, please explain: _____ Placement date _____

- Are you now under the care of a physician or have any health problems that need clarification? ☐Yes ☐ No

  If yes, please explain: _____

- Name of Physician: _____ Phone: _____

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

I _____hereby grant consent to treat my minor child named above.
Signature of parent or guardian