

# ALL PRO DENTAL

## PATIENT INFORMATION

*Welcome to our office! To assist us in serving you, please complete the following confidential form.  
The information provided is important to your dental health.*

Patient's name	Birthdate	Age
If minor, Legal Guardian name _____		
Relationship to Patient _____		
Home phone _____	Cell Phone _____	
Mailing address _____	City _____	State _____ Zip _____
Email address _____		
Whom may we thank for referring you to our office? _____		

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?  
(Please check any that apply)

**No Medical Conditions**

- Anemia
- Arthritis
- Asthma
- Artificial joint or valve
- Blood Disease
- Chemo (cancer/leukemia)
- Cortisone Medicine
- Diabeters
- Epilepsy or seizures
- Emphysema
- Glaucoma
- Herpes
- Heart Disease
- Heart Murmur
- Heart Pacemaker
- Hay Fever
- HIV
- Hepatitis
- Hemophilia
- High Blood Pressure
- Kidney Trouble
- Nervousness
- Pain in Jaw Joints
- Sickle cell Disease ot Trait
- Ulcers
- Thyroid Disease
- Other: \_\_\_\_\_

Are you allergic to, or have you reacted adversely to any of the following?

**No Known Drug Allergies**

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: \_\_\_\_\_

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

\_\_\_\_\_  
Name of your physician: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if any medicines change I will inform my dentist at the next appointment.*

**Signature of patient (or parent)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Doctors Signature** \_\_\_\_\_ **Date** \_\_\_\_\_