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 _____**