Personal Health Information

Name: _____ Preferred name: _____Date of Birth: _____
(First) (MI) (Last) *(Month/Day/Year)*

Phone: (_____) _____ Cell Phone: (_____) _____ SSN: _____

Mailing Address: _____ E-mail _____
(Street) (City) (Zip)

Would you like to receive notifications/appointment reminders by email? Yes: __ No: __

Married: ____ Single: ____ Child: ____ Male:____ Female:____

Insurance information (If none leave blank)

Employer:_____ Primary Insurance: _____ Secondary Insurance_____

How did you hear about our office? Friend: _____ Online: _____ Referral: _____ Other: _____

(Some medical conditions influence dental health and alter treatment protocol)

Medications- Please list the medications you are currently taking:

Antibiotics: _____
Bisphosphonate (Fosamax)
Blood thinners:_____
Blood pressure meds: _____
Chemotherapy
Chocolates: _____
Tranquilizers: _____
Contraceptive: _____
Hormones: _____
Insulin: _____
Muscle relaxants: _____
Pain relievers: _____
Stimulants: _____
Thyroxin: _____

Please List Other Medications:
Including homeopathic:
_____
_____
_____

Circle if you have or have you had any of the following medical conditions or procedures:

Health conditions:

- Alcoholism/drug dependence
- Cancer
- Diabetes A1C:_____
- Eating disorder
- Emphysema
- Fainting/seizures/epilepsy
- Glaucoma
- Headaches severe/frequent
- Hepatitis
- HIV+AIDS/ARC
- Kidney problems
- Sexually transmitted disease
- Sleeping disorder
- Snoring
- Thyroid problems
- Tobacco use
- Vaping/Nicotine
- Cannabis use
- Autism Spectrum:
- ADD/ADHD

Heart/circulation conditions:

- Heart attack
- High/low blood pressure
- Bacterial endocarditis
- Bleeding or bruising problem
- Congenital heart defect
- Chest pains
- Heart valve defects/replaced
- Heart murmur
- Mitral valve prolapse
- Pacemaker
- Rheumatic fever
- High Cholesterol

Joints and bones:

- Arthritis / rheumatism
- Back/spinal problems
- Joint replacement

Allergies:

- Penicillin allergy
- Medication allergies
- Skin rashes
- Latex allergy

Respiration conditions:

- Asthma
- Difficulty breathing
- Sinus infections
- Tuberculosis, TB

For women:
Birth control pills
Are you pregnant? Yes No
Are you nursing? Yes No

Please list any other allergies, medical condition(s), or surgeries (with dates) you **have** or **ever had**:

_____
_____

Signature: _____ Date: _____
(Patient or Parent/Guardian)

EMERGENCY CONTACT: PHONE NUMBER: