

# Patient Information Sheet

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Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_ Responsible Party \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Spouse/Guardian \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date of Last Physical \_\_\_\_\_ Are you in good health? \_\_\_\_\_

Serious Illness/Surgery in Last 5 Years \_\_\_\_\_

List any medication you are presently taking. \_\_\_\_\_

Have you ever been told by a doctor that you need to take antibiotics (pre-medication) before dental treatment? \_\_\_\_\_

If yes, what antibiotic? \_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_

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## Please Circle Yes or No

Yes No Hepatitis/Liver Disease

Yes No Rheumatic Fever

Yes No Heart Disease

Yes No Heart Murmur

Yes No Diabetes

Yes No Sinus Trouble

Yes No Asthma/Hay Fever

Yes No Kidney Disease

Yes No Abnormal Bleeding

Yes No Hip/Joint Replacement

Yes No Do you use tobacco

Yes No Do you take aspirin  
Regular \_\_\_ Daily \_\_\_

Yes No Are you pregnant at this time?

Yes No Allergies to medication  
If so, list \_\_\_\_\_

Yes No Allergies to anesthetics  
If so, list \_\_\_\_\_

Yes No Arthritis

Yes No Tuberculosis

Yes No High Blood Pressure

Yes No Epilepsy

Yes No Blood Transfusion

Yes No Positive Test Result for HIV or AIDS Virus

Yes No Do you take blood thinning medications?

Signature of Patient (or Responsible Party) \_\_\_\_\_ Date \_\_\_\_\_

