NEW PATIENT INFORMATION SHEET

Patient's Name:	Date of Birth:/
(Please print) Street Address	Social Security #:
	tus: \square Married \square Single \square Divorced \square Separated \square Widowed
	Work Phone: ()
STUDENT INFORMATION	
Name of School:	
(Please circle one): Part Time (Less than 12 units) -	
EMERGENCY CONTACT	
	hone #: () Relationship:
GUARANTOR INFOR	RMATION IF PATIENT IS A MINOR
Guarantor's Name:	Home Phone: ()
Address:	
	Work Phones ()
Name of Employer:	work Flione: (
If the patient's parents are separated, with whom d	
If the patient's parents are separated, with whom d Primary General Dentist: Physician:	loes the patient reside? Name:
If the patient's parents are separated, with whom d Primary General Dentist: Physician:	loes the patient reside? Name:
If the patient's parents are separated, with whom deprimary General Dentist: Physician: Whom may we thank for referring you to out	loes the patient reside? Name:
If the patient's parents are separated, with whom deprimary General Dentist: Physician: Whom may we thank for referring you to out Primary Insurance	loes the patient reside? Name:
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HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N) 1. Are you in good health? 2. Has there been any change in your general health? 3. Date of last physical avam. 4. Are you now under a physical ars care for a particular problem? 5. Have you ever had any sentous illnesses. 6. Height Weight 7. DO YOU HAVE OR HAVE YOU EVER HAD: 8. Congenital Heart Disease? 9. N. B. Congenital Heart Disease? 1. C. Cardrowscults Disease (Heart Attack, Heart Trouble, Heart Murrar, Coronary Artery Disease, Angins, High Blood Pressure, Stroke, Poliptations, 1. Height Weight 7. DO YOU HAVE OR HAVE YOU EVER HAD: 8. Congenital Heart Disease? 9. N. B. Congenital Heart Disease? 1. Y. N. B. Congenital Heart Disease. 1. Arthorized the production of the produc	Pa	tient's	s Name			Date
2. Has there been any change in your general habith in the past year? Y N Beneral Phase in the past year? Y N Are you now under a physician's care for a particular problem? Separation of the past drug? Y N Habit your under a physician's care for a particular problem? Separation of hospitalizations? If so, describe Y N N Habit your health year of heave you ever had any serious linesses, operations or hospitalizations? If so, describe Y N N P Do You HAVE OR HAVE YOU EVER HAD: A. Rheumatic Fever or Rheumatic Heart Disease? Y N B. Congential Heart Disease? Y N B. Congenial Heart Disease. Provide your Septiment of the part of the	Ar	ısweı	r all questions by circling Yes (Y) or No (N)			All responses are kept confidential
general health in the past year? Y N 4. Are you now under a physical exam 5. Date of last physical exam 6. Holght Weight 7. DO YOU HAVE OR HAVE YOU EVER HAD: 7. DO YOU HAVE OR HAVE YOU EVER HAD: 8. Congenital Heart Disease? Y N 8. Congenital Heart Disease? Y N 9. C. Cardiovascular Disease (Heart Attack, Heart 7. Torouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Papitations, Heart Surgery, Pacamaker?) Y N 9. Lung Disease (Asthan, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughingly? Y N 9. Seizuces, Cornvulsions, Epilepsy, Fainting or Dizziness or Breath, Chest Pain, Severe Coughingly Y N 1. Diabetes? Y N 1. Diabetes? Y N 1. Diabetes? Y N 1. Diabetes? Y N 2. Strough Disease (Galent?? Y N 3. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Kneel? Y N 3. Radiation (X-ray) treatment for Cancer? Y N 4. Rodrey Disease, Complision (X-ray) treatment for Cancer? Y N 5. Radiotion (X-ray) treatment for Cancer? Y N 6. Radiotion (X-ray) treatment for Cancer? Y N 7. Radiotion (X-ray) treatment for Cancer? Y N 8. Radiotion (X-ray) treatment for Cancer? Y N 9. Radiotion (X-ray) treatment for Cancer? Y N 9. Radiotics (Cortisone, etc.)? Y N 9. Radiotion (X-ray) treatment for Cancer? Y N 9. Radiotion (X-ray) treatment for Cancer? Y N 9. Radiotics (Blood Thinners)? Y N 9. Radiotics (Gordisone, etc.)? Y N 9. Radiotics (Gordisone, etc.)? Y N 9. Radiotics (Gordisone, etc.)? Y N 9. Captino or there aribibles or Y N 9. Captino or there aribibles or Y N 9. Captino or there aribibles or Y N 9. Captino or the radiotics? Y N 9. Captino or the radiotics and sortics the doctor privately about anything? Y N 9. Captino or drangs such as M	1.	Are	you in good health?Y	N		F. Tranquilizers?Y N
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6. Height Weight	5.	Hav	e you ever had any serious illnesses,			
7. DO YOU HAVE OR HAVE YOU EVER HAD: A. Rheumatic Fever or Rheumatic Heart Disease? Y. N. B. Congenital Heart Disease? Y. N. B. Congenital Heart Disease? Y. N. B. Congenital Heart Disease? Y. N. B. Penicillin or other antibiotics? Y. N. N. Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke Palpitations, Heart Surgery, Pacemaker? Y. N. P. Lung Disease (Ashman, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y. N. D. Lung Disease (Ashman, Emphysema, Chronic Disease (Ashman, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y. N. P. Electing Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruse easily? Y. N. B. Rediging Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruse easily? Y. N. D. Diabete? Y. N. D. Diabe		opei	rations or hospitalizations? If so, describe:Y	N 		
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D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Preumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness. Shortness of Breath, Chest Pain, Severe Coughing)? R. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?. Y N 11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N 12. Have you had any serious problems associated with any previous dental treatment? Y N 13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N 14. Do you have any other dasse, condition or problem not listed above that you think the doctor should know about? A. Rate You UsinG ANY of THE FOLLOWING: A Antibiotics? Y N 15. Do you wish to talk to the doctor privately about anything? Y N 15. Por Wollen Onlt? A 2 Net you Drivately and you will need to use mechanical forms of the control pills, after the course of antibiotics of other medications, and the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History dated and confirm that it adequately states past and present conditions. Date				N		
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I. Diabetes?					12.	
J. Thyroid Disease (Goiter)? Y N						
K. Arthritis?					13.	
L. Stomach Ulcers or Colitis?					4.4	
M. Glaucoma?					14.	
N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N O. Radiation (X-ray) treatment for Cancer? Y N 16. FOR WOMEN ONLY P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N O. Sinus or Nasal problems? Y N O. Sinus or Nasal problems? Y N N N O. Sinus or Nasal problems? Y N N N O. Sinus or Nasal problems? Y N N N N N N N N N N N N N N N N N N						
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O. Radiation (X-ray) treatment for Cancer? Y N Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N B. Are you Pregnant, or is there any chance you might be Pregnant? Y N B. Are you nursing? Y N S.		IN.		N	13.	
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difficulty opening mouth, grind or clench teeth?Y N Q. Sinus or Nasal problems?				• •		
Q. Sinus or Nasal problems?				Ν		
R. Any disease, drug or transplant operation that has depressed your immune system?						
8. ARE YOU USING ANY OF THE FOLLOWING: A. Antibiotics?						C. If you are using Oral Contraceptives, it is important
A. Antibiotics?			that has depressed your immune system?Y	Ν		that you understand that antibiotics (and some other
B. Anticoagulants (Blood Thinners)?	8.					medications) may interfere with the effectiveness of oral
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your E. Steroids (Cortisone, etc.)?						
D. High Blood Pressure medications?						
E. Steroids (Cortisone, etc.)?						
I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor. Date Signature of Person Completing Health History Doctor's Initials Medical Update: I have ready my Health History dated						
Date Signature of Person Completing Health History Doctor's Initials Medical Update: I have ready my Health History dated and confirm that it adequately states past and present conditions. Date Exceptions or changes Patient's Signature Doctor's Initials		E.	Steroids (Cortisone, etc.)?	IN		physician for further guidance.
Date Signature of Person Completing Health History Doctor's Initials Medical Update: I have ready my Health History dated and confirm that it adequately states past and present conditions. Date Exceptions or changes Patient's Signature Doctor's Initials				assis	t the doc	ctor in providing the best care possible. I have had the
Medical Update: I have ready my Health History dated	op	portu	nity to discuss my Heath History with my doctor.			
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Medical Update: I have ready my Health History dated	Da	te	Signature of Pers	son Co	mpleting	Health History Doctor's Initials
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