

JEFFERSON DENTAL ASSOCIATES

Date: _____

Patient Information

Please Print

Patient Name: _____ Dr./Mr./Mrs./Miss/Ms
Last | First | MIPreferred Name: _____ Male Female Married Single Child

Birth Date: _____ Social Security #: _____

Address: _____
Street | Apartment # |

City: _____ State: _____ Zip code: _____

E-mail: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

(Fax) _____ Mobile _____ (Other) _____

HEALTH INFORMATION

Date of Last Dental Visit: _____

Chief Dental Complaint: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | Sinus Problems | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Are you allergic to any medications ? (i.e. penicillin, novocaine, etc.) _____
- Have you ever had excessive bleeding? Yes No
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any drugs or medications? Yes No
If yes, please list: _____
- Person to notify in case of emergency: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

