Patient Information			Allergies		
Name:		<u>.</u>	□Aspirin	□Latex	□Sulfa
			□ Barbiturates□ Codeine	☐ Local Anesthetic ☐ Penicillin	□None
City:	State:	Zip Code:			
Phone (Home):	(Cell):		Other:		
Birth Date:	SS#:				
Email:			Madiantian	. Decement of Court	the Country
☐ Male ☐ Female	☐ Single	☐ Married ☐ Minor	iviedications	s – Prescription & Over	the Counter
Employer:					
Spouse/Partner phone num	ber:]		
Emergency Contact:					
	Phone:				
			,		
	Health Information				
Have you ever or do you cui	rrently have any of the following	ng?			
☐ AIDS/HIV	☐ Headaches	☐ Radiation Treatment			
☐ Anemia	☐ Heart Disease	☐ Respiratory Problems			
☐ Asthma	☐ Heart Murmur	☐ Rheumatic Heart Disease			
☐ Bad Breath	☐ Hepatitis, type	☐ Rheumatic/Scarlet Fever			
☐ Blood Disease	☐ High/Low Blood Pressure	☐ Rheumatism/Arthritis			
☐ Cancer/Chemotherapy	☐ High/Low Cholesterol	☐ Sensitive Teeth			
☐ Chemical Dependency	☐ Jaw Pain	☐ Shortness of Breath	Me	edical History Updat	es
☐ Clicking/Popping Jaw	☐ Joint Replacement	☐ Sinus Problems			
☐ Congenital Heart Defect	☐ Kidney Disease	☐ Stomach Problems			
☐ Cortisone Treatments	☐ Liver Disease	☐ Stroke			
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Swollen Feet/Ankles			
☐ Emphysema	☐ Nervous Problems	☐ Thyroid Problems			
☐ Epilepsy	☐ Pacemaker/Defibrillator	☐ Tobacco Use/Smoking			
☐ Excessive Bleeding	☐ Periodontal/Gum Disease	☐ Tuberculosis			
☐ Fainting/Dizziness	☐ Prosthetic Heart Valve	Ulcers			
☐ Grinding/Clenching	☐ Psychiatric Care	☐ Venereal Disease			
Drognonov ovnostod dvo	data	Nursing Voc / No			
	date:				
☐ None of these apply		Initials:			
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utc					
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