



New Patient Information

First Name _____ MI _____ Last Name _____ (Preferred Name) _____

Date of Birth _____ Age _____ M ☐ F ☐

How did you hear about us? _____

Your Address _____ City _____ State _____ Zip _____ Primary Phone _____ Secondary Phone _____

Patient Health History

(Please answer ALL questions)

Heart Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Handicapped	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Head Lice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Prosthetic Joints or Pins	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Liver/GI Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lung/Breathing Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ADHD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered "yes" to any of the above, please explain: _____

- Does the patient have any dental problems/concerns at this time? (check all that apply:) ☐ None
☐ Decay ☐ Pain ☐ Grinding ☐ Trauma ☐ Orthodontics ☐ Aesthetics ☐ Infection ☐ Other: _____
- Does the patient require antibiotics prior to dental treatment? Yes ☐ No ☐ If "yes", what type? _____
- Is the patient taking any medications at this time? Yes ☐ No ☐ If "yes", what type? _____
- Is the patient allergic to any medications/materials commonly used in a dental office (latex gloves, anesthesia)? Yes ☐ No ☐
 If "yes", what kind? _____

Parent/Guardian Information

Mother/Guardian Name _____ Employer _____ Father/Guardian Name _____ Employer _____

Address _____ City _____ State _____ Zip _____ Phone # _____ Work or Cell # _____

Nearest Relative not living w/Patient _____ Relationship _____ Phone # _____

* I understand I cannot leave the property while my child is being attended. If I leave, the proper authorities may be notified of my absence. I certify I have read and understand the above. I acknowledge my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other members of his/her staff, responsible for any errors or omissions I may have made in the completion of this form.

Parent/Guardian Signature _____

Date _____