



NEW PATIENT MEDICAL FORM



Patient Name: _____

Health Information

Do you have, or have you had any of the following? Please check those that apply

For both adults/child:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Smoker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis circle: (A,B,C)	# Cigarettes/Day _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	# Yrs Smoked _____
<input type="checkbox"/> Artificial joints or implants?	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stomach Problems
Location of implant: _____	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental or Nervous Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Excessive Bleeding	Due Date: ____/____/____	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Drug Allergies: _____
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Rheumatic Fever	_____
	<input type="checkbox"/> Rheumatism	_____

For our children patients (Check those that apply):

- Measles yes/no, chicken pox yes/no,
- Mononucleosis yes/no, ADD/ADHD yes/no,
- Mumps yes/no, Sinus Problems yes/no,
- Autism yes/no, Artificial limb/metal implant yes/no

Current Medications: _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- 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: _____
- Do you have any health problems that need further clarification? Yes No If yes, please explain: _____



NEW PATIENT DENTAL FORM



Dental Information

Do you have, or have you had any of the following? Please check all those that apply

For both adults and children:

<input type="checkbox"/> Do you have sensitive gums?	<input type="checkbox"/> Allergy to Antibiotics? (i.e. penicillin)
<input type="checkbox"/> Do you have headaches?	<input type="checkbox"/> Allergy to Iodine?
<input type="checkbox"/> Are your teeth sensitive to hot/cold?	<input type="checkbox"/> Allergies to Sulfa drugs?
<input type="checkbox"/> Have you had difficult extractions in the past?	<input type="checkbox"/> Allergic to Sedatives?
<input type="checkbox"/> Do you grind your teeth?	<input type="checkbox"/> Allergic to Barbiturates?
<input type="checkbox"/> Have you had a previous negative dental experience?	<input type="checkbox"/> Allergic to metals (i.e. nickel, mercury?)
<input type="checkbox"/> Do you floss regularly?	<input type="checkbox"/> Allergic to Aspirin?
<input type="checkbox"/> Have you a negative reaction to Novocain?	<input type="checkbox"/> Allergic to Latex Rubber?

For our children patients:

Does your child have a habit of: Lip Sucking/Biting?

Does your child have a habit of Nail Biting?

Does your child have a habit of Thumb/Finger Sucking?

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.

X

Signature of patient, parent or guardian

X

Date: