Patient Information Form

NOTE: The information on these forms is necessary for our records. It is considered strictly confidential. Please complete all parts.

◯ Miss
◯ Mrs.
◯ Mr.____

Last First Middle

DOB: _____/_____/_____ Marital Status: _____ Sex: F ____ M ____

Social Security Number: _____-_____-_____

Address: ____

Street Apt# City State Zip Code

Home Phone: ________________________ Cell Phone: _______________________

E-Mail Address: ____

Driver's License #: _______________________ State: _______

Occupation: ___________________ Work Address: _____________________________

Do you have a primary physician? ◯ Yes ◯ No

Primary Physician's Name: ____

Primary Physician's Number: _______________________ Physician's Fax: _________________

What do you want us to do for you? ____

Who recommended you to our office? ____

EMERGENCY CONTACT INFORMATION(PERSON/RELATIVE NOT LIVING WITH YOU)

Name: ________________________________ Phone Number: ____________________

Relationship to Patient: _____________________

Address: ____

Street Apt# City State Zip Code

Medical-Dental History Form

Name: ____ DOB: ____/____/____

Address: _______________________________________ SSN: _____-____-_____

E-Mail Address: __________________________________

Home Phone: ____________________ Cell Phone: ___________________

Marital Status: _____ Sex: F___ M____ Date of Last Physical Exam: ___/___/___

Have you ever been a patient in a hospital or had any serious illness? Yes ____ No ____

Explain: ____

Check any of the following that you have had or suspected:

___ AIDS/HIV
___ Anemia
___ Arthritis
___ Asthma
___ Bladder Trouble
___ Blood Disease
___ Blood Transfusion
___ Cancer
___ Chest Pain
___ Diabetes
___ Dizziness
___ Epilepsy
___ Excessive Bleeding
___ Fainting Tendency
___ Glaucoma
___ Hay Fever
___ Heart Disease
___ Heart Murmur
___ Heart Trouble
___ Hepatitis
___ High Blood Pressure
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Mental Disorders
___ Pacemaker
___ Prosthetic Joint Replacement
___ Radiation Treatment
___ Rheumatic Fever
___ Sinus Trouble
___ Shortness of Breath
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Tumor
___ Venereal Disease
Other: __________________

Check any of the following that you have taken or are currently taking:
___ Anticoagulants ___ Cortisone Drugs ___ Sedatives
___ Blood Thinners ___ Tranquilizers ___ Steroids

Are you allergic to or do you suffer ill effects from any of the following?
___ Penicillin ___ Aspirin ___ Codeine
___ Dental Anesthesia ___ Household Bleach Other: ____________________

Do you smoke? Y ___ / N ___ Do you drink alcohol? Y ___ / N ___

Are you pregnant? Y ___ / N ___ If yes: How many months? ___ Are you breastfeeding? ___

Are you taking medication? Y ___ / N ___ If yes, please list them below:

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

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