

Returning Patients:

Patient Name: _____

Phone Home: _____ Phone Cell: _____ Phone Work: _____ Phone Emergency: _____

Email Address: _____

Address: _____

Employer: _____

Prescriptions or Medications: (new) _____

Continuing Medical Conditions: (new) _____

Other Changes or Important Information: _____

Check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Allergies to Drugs | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergies to Medicine | <input type="checkbox"/> Heart Artificial Valves | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Allergies (General) | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Immunosuppressive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | | |
| <input type="checkbox"/> Are you or do you suspect that you may be pregnant? | | |

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____