

PATIENT INFORMATION
(Information will be held in strict confidence)

A B C

"Please Print"

Date: _____

How were you referred to our office? _____

Name: _____
Last First Middle Marital Status

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

How Long at this address: _____ Home Phone: _____ Work Phone _____

Previous Address (if less than 3 yrs.): _____
Street City State Zip

Social Security #: _____ Birthdate: _____ M _____ F _____

Employer: _____ Occupation: _____ No. Years Employed _____

If patient is a minor, give parent's or guardian's name: _____

Email address: _____ Cell Phone Number: _____

FINANCIALLY RESPONSIBLE PERSON

(If Different from Patient)

Name: _____
Last First Middle Marital Status

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

How Long at this address: _____ Home Phone: _____ Work Phone _____

Previous Address (if less than 3 yrs.): _____
Street City State Zip

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed _____

SPOUSE'S INFORMATION

Spouse's Name: _____
Last First Middle

Employer: _____ Occupation: _____ No. Years Employed _____

Social Security #: _____ Birthdate: _____ Work Phone: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship to Patient: _____

I understand that where appropriate, credit bureau reports may be obtained.

Updates (date & initial) _____

(Please Complete Medical History On Back)

TAYLOR DENTAL ASSOCIATES, INC.

MEDICAL HISTORY

Name of Medical Doctor (Physician) _____

Physician Address _____ Phone Number _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____Are you on a special diet? ☐ Yes ☐ No _____Do you use tobacco? ☐ Yes ☐ No _____Do you use controlled substances? ☐ Yes ☐ No _____

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain In Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____