PHILLEY DENTISTRY

PATIENT INFORMATION

DATE:

Name:	DOB:	Cell number: Other number:	
Address:	City:	State:	Zip:
E-mail:		Single ☐ Married ☐	
Name of Employer:	Business Address:		
Driver's License #:	Social Security #:		
Whom may we thank for referring you?			

PATIENT MEDICAL HISTORY

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you been hospitalized in the past 5 years for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
4. Do you use tobacco products? How often? _____	☐	☐
5. Do you drink alcohol?	☐	☐
6. Do you use recreational drugs?	☐	☐
8. Are you currently taking osteoporosis medication?	☐	☐

List of current medication(s):

_____

_____

_____

_____

_____

_____

7. Are you allergic to any of the following? (check box if yes)

☐ Local anesthetics (eg. Novocaine) ☐ Penicillin ☐ Other antibiotics ☐ Sulfa drugs ☐ Sedatives ☐ Aspirin

☐ Other (please list) _____

9. Women only: a. Are you pregnant or think you may be? Y ☐ N ☐ b. Nursing? Y ☐ N ☐

c. Taking birth control pills? Y ☐ N ☐

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10. Do you have or have you had any of the following? (check box if yes)

☐ AIDS OR HIV INFECTION	☐ FREQUENTLY TIRED	☐ LOW BLOOD PRESSURE
☐ ANEMIA	☐ GLAUCOMA	☐ RADIATION THERAPY
☐ ANGINA	☐ HAY FEVER/ALLERGIES	☐ RECENT WEIGHT LOSS
☐ ARTHRITIS	☐ HEART ATTACK	☐ RESPIRATORY PROBLEMS
☐ ASTHMA	☐ HEART DISEASE	☐ RHEUMATIC FEVER
☐ CANCER	☐ HEART MURMUR	☐ SEXUALLY TRANSMITTED DISEASE
☐ CARDIAC PACEMAKER	☐ HEART TROUBLE	☐ STOMACH TROUBLES/ULCERS
☐ CHEST PAINS	☐ HEPATITIS/JAUNDICE	☐ STROKE
☐ DIABETES	☐ HIGH BLOOD PRESSURE	☐ SWOLLEN ANKLES
☐ EASILY WINDED	☐ JOINT REPLACEMENT OR IMPLANT	☐ THYROID PROBLEM
☐ EMPHYSEMA	☐ KIDNEY DISEASES	☐ TUBERCULOSIS
☐ EPILEPSY/CONVULSIONS	☐ LEUKEMIA	☐ OTHER _____
☐ FAINTING/SEIZURES	☐ LIVER DISEASE	_____

Signature: X _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.