Patient Information and Health History

Name _____DOB _____ Age_____ Social Security#_____

Mailing Address_____City_____ZipCode_____

Email_____Home Number_____Cell Number_____

How did you hear about our office?_____

Your Occupation _____ Employer _____Work Number_____

Spouse Name (if applicable)_____DOB_____Employer_____Social Security#_____

Dental Insurance _____ Group or Plan # _____

Person to contact in case of Emergency _____ Phone Number_____

Physician_____ Address_____ Phone Number_____

Are you in good health? _____ If no, please explain_____

Have you been hospitalized in the past two years? _____ If yes, please explain _____

List all medications or drugs you are taking _____

Do you now have, or have you had any of the following? (If yes, please describe under remarks)

	YES	NO			YES	NO
Heart Disease	☐	☐	Diabetes		☐	☐
High Blood Pressure	☐	☐	Epilepsy		☐	☐
Blood Disease	☐	☐	Tumor History		☐	☐
Rheumatic Fever	☐	☐	Radiation Treatment		☐	☐
Heart Murmur	☐	☐	Kidney Disease		☐	☐
Mitral Valve Prolapse	☐	☐	Liver Disease		☐	☐
Stroke	☐	☐	Asthma		☐	☐
Do you have a pacemaker?	☐	☐	Tuberculosis		☐	☐
Do you bleed excessively when cut?	☐	☐	Hepatitis		☐	☐
Arthritis	☐	☐	AIDS or HIV Positive		☐	☐
Artificial Joints	☐	☐	Other Sexually Transmitted Diseases		☐	☐
Osteoporosis	☐	☐	Allergy to:	Penicillin	☐	☐
Do you use tobacco?	☐	☐		Codeine	☐	☐
Are you pregnant?	☐	☐		Local Anesthetics	☐	☐
				Latex	☐	☐
				Other	☐	☐

Remarks or any other medical conditions not listed above _____

Is there anything you want to change about your smile?_____

Do you have any present dental complaints?_____

When was your last full mouth x-ray taken? _____When was your last cleaning? _____

I have thoroughly completed this form and have not excluded any important medication information. I also agree to assume full financial responsibility for all treatment rendered. I also give Charles R. White II, DDS permission to file insurance claims on my behalf.

Signature _____ Date_____