PREMIER DENTISTRY

Patient Information

Last Name: _____ First Name: _____ MI: ___ Today's Date: _____

Gender: _____ Family Status: _____ Social Security #: - - Birth Date: _ ____/_____/_____

Phone (mobile): _____ Phone (Home): _____ Phone (Work): _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Health Information

Have you ever had any of the following? Please **check** those that apply:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Blood Diseases
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Head injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis- A, B, C
- ☐ Hay Fever
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder- Depression
- ☐ Migraines
- ☐ Nervous Disorder – Anxiety
- ☐ Pacemaker
- ☐ Pregnancy Due **Date:_____**
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Skin Disorders
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER: _____

Please list any medications you are currently taking: _____

Do you smoke: **Yes** **No** Do your gums ever bleed: **Yes** **No** Do you have any loose teeth: **Yes** **No**

Does food catch between your teeth? **Yes** **No** Are your teeth sensitive to **heat** or **cold**?

Do you have a specific dental concern? _____ Are you currently in pain? **Yes** **No**

Have you ever had any complication following dental treatment? Please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? **Yes** **No**

Are you now under the care of a physician? **Yes** **No** Name of Physician: _____

Do you require antibiotics before dental treatment? **Yes** **No**

Are you happy with the way your smile looks? **Yes** **No** if not what would you change? _____

- **Emergency Contact:** _____ Relationship: _____ Phone Number: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

- **Signature of patient, parent or guardian** _____ **Date**: ___/___/_____