Patient Information

Patient Name: _____

Last Name First Name MI Preferred Name

Email Address: _____ May we contact you by e-mail? ☐Y ☐N

Social Security #: _____ Birthdate: _____ Gender: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Address: _____

Street City State Zip

Health Information

Date of last dental visit: _____ Reason for visit: _____

Have you ever had or currently have any of the following? Please check all that apply:

- ☐ Anesthetic Allergy
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Ibuprofen Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Shellfish Allergy
- ☐ Other Allergies (list):

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back/Neck Problems
- ☐ Taking Bisphosphates
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Chron's
- ☐ COPD
- ☐ Taking Coumadin
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Mental Health Issues
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Taking Plavix
- ☐ Pregnancy
  Due Date:
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disorder - hypo
- ☐ Thyroid Disorder - hyper
- ☐ TMJ/TMD
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Ulcerative Colitis
- ☐ Tobacco Use?
  Type & Amount/day:
- ☐ Recreational Drug Use?
  Type(s) and Most Recent Dates of Use:
- ☐ Other Health History:

LIST ALL MEDICATIONS:

☐Y ☐N - Have you ever had any complications following dental treatment? If yes, please describe:

☐Y ☐N - Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please describe:

☐Y ☐N - Have you been under the care of a physician for a medical condition (within the past year)? If yes, please describe:
Name of Physician:

☐Y ☐N - Do you have any health problems that need further clarification? If yes, please describe:

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 Dr. Yarbro at my next appointment without fail.

_____

Signature of patient or legal guardian Date

Referral Information

How did you hear about our office and/or whom may we thank?

Notes (Office Use Only):