



Name (First, MI, Last): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email: _____

Birthday: _____ SSN: _____

Male Female Married Single Is Child

History

Please indicate if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Tumors | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Other | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Diabetes 1 | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Diabetes 2 | <input type="checkbox"/> Venereal Disease |

Premedication

Do you need to be pre-medicated with antibiotics prior to dental procedures? Yes No

Medications

Please list any medications your are currently taking: _____

Allergies

Please list any medications you are allergic to: _____

Are you allergic to Latex? YES NO

Dr. John Patterson may use my health care information and may disclose such information to the above-named insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient / Legal Guardian Signature

Date