JP | John Patterson, D.M.D.

# PATIENT INFORMATION FORM

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:

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