Family & Aesthetic Dentistry
of
South Riding

Patient Information
(Please Print)

Patient Name:______________________________________ Preferred:______________________ Date__________
Last First M.I.

( ) Male ( ) Female ( ) Married ( ) Single ( ) Child ( ) Other

Social Security #_____________________ Birth Date ____________ Email_________________________________

Phone (H)_____________________ (W)_______________________ (C) ___________________________________

Address____
Street Apartment#

____
City State Zip Code

Health Information

Date of Last Dental Visit________________ Reason for Today's Visit_____________________________

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

___	AIDS	___	Stroke	___	Kidney Disease	___	Drug Addictions
___	Allergies	___	Emphysema/COPD	___	Liver Disease	___	Stomach problems
___	Codeine Allergy	___	Epilepsy	___	Mental Disease	___	Tobacco Use
___	Latex Allergy	___	Excessive Bleeding	___	Mitral Valve Prolapse	___	Tuberculosis
___	Penicillin Allergy	___	Diabetes	___	Nervous Disorders	___	Thyroid Problem
___	Metal Allergy	___	Frequent Headaches	___	Pacemaker	___	Ulcers
___	Anemia	___	Glaucoma	___	Pregnant	___	Ringing in Ears
___	Arthritis	___	High Blood Pressure		Due Date__________	___	Sinus Problems
___	Artificial Joints	___	Head Injuries	___	Radiation Treatment	___	STD
___	Asthma	___	Heart Disease	___	Respiratory Treatment	___	Hay Fever
___	Blood Disease	___	Heart Murmur	___	Rheumatic Fever	___	Dizziness
___	Cancer	___	Heart Surgery	___	Hepatitis	___	Fainting

Do you have any health problems that need further Clarification?____

Are you now under the care of a physician? ( ) Yes ( ) No Name of Physician:_______________________________

If yes, please explain:____

Please list all medications you are currently taking (prescription and over the counter)__________________________

____

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

If yes, please explain:____

Have you ever had any complications following dental treatment? ( ) Yes ( ) No

If yes, please explain:____

Have you had serious injuries/problems of the head, face, jaw or TMJ? ( ) Yes ( ) No

Have you or a family member ever lost teeth to gum or periodontal disease? ( ) Yes ( ) No

Are you currently or have you ever had orthodontic treatment? ( ) Yes ( ) No

Have you ever been recommended to pre-medicate before dental procedures? ( ) Yes ( ) No

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

____ Date_____________________________
Signature of patient, parent or guardian

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