

Chart #.

FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:
 City State Zip Code

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:
 City State Zip Code

Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

- | | | |
|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's/Dementia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy TX |
| <input type="checkbox"/> Clindamycin Allergy | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Drug Dependancy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Erythro Allergy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Disease/Surger | <input type="checkbox"/> Heart Murmur/MVP | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Migraines | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment |

- Reflux
- Rheumatism
- Stomach Problems
- Thyroid Disease
- Ulcers
- Respiratory Diseases
- Sinus Problems
- Stroke
- Tuberculosis
- Rheumatic Fever
- Stents
- Sulfur Allergy
- Tumors

Please list ALL allergies to drugs, food, dye, etc

Medical Notes:

Are you now under the care of a physician for anything other than routine care?

- Yes
- No

If yes, please explain:

Physicians name, address, phone number:

Blood Pressure

Temperature

Have you been outside of the United States in the 21 days? If so, where?

Please list all medications including dosage that you are currently taking (especially blood thinners):

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What would you like to change most about your smile?

I hereby, give permission to Terrace Hill Dental Center, PLLC, to provide treatment/services for me or the person I am signing for.

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: _____

Date:

Response Date: