DENVER DENTAL CARE

About You

Today's Date: ___ / ___ / _____ File #: _____

Patient Name: _____

What You Prefer to Be Called: _____ M ___ F ___

Birthdate: ___ / ___ / _____ Age: _____ SS#: _____

Mailing Address: _____

_____

CITY STATE ZIP

Home Phone # _____ Work Phone # _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____

CITY STATE ZIP

Occupation: _____

Status: ___ Minor ___ Single ___ Married ___ Divorced ___Separated ___Widowed

Spouse's Name: _____

Account Info

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

Work Phone # _____

DENVER
DENTAL CARE

In Event Of Emergency

Who should we contact? _____

Relation: _____

Home Phone # _____ Work Phone # _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

Medical History

Please list any medication you are currently taking: _____

_____

_____

Do you have or ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke
Y N Heart Sug. / Pacemaker
Y N Heart Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves
Y N Heart Disease
Y N Congenital Heart Defect
Y N Chest Pains
Y N Scarlet Fever
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems

Y N Sinus Problems
Y N Stomach Problems / Ulcers
Y N Psychiatric Problems
Y N Venereal Disease
Y N Alcohol / Drug Abuse
Y N Tuberculosis TB
Y N Jaw Problems TMJ / TMD
Y N Cancer / Tumors
Y N Shingles
Y N Hepatitis
Y N HIV+ / AIDS / ARC
Y N Arthritis / Rheumatism
Y N Artificial Bones / Joints

Y N Emphysema
Y N Fainting / Seizures / Epilepsy
Y N Severe / Frequent Headaches
Y N Frequent Neck Pain
Y N Chemotherapy
Y N Asthma
Y N Difficulty Breathing
Y N Diabetes / Hypoglycemia
Y N Leukemia
Y N Anemia
Y N High / Low Blood Pressure
Y N Glaucoma
Y N Back Problems

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Please list any other medical condition (s) you have or ever had: _____

_____

Are you allergic to any of the following: ___ Latex ___ Penicillin / Amoxicillin ___ Tetracycline
___ Aspirin ___Dental Anesthetics ___ Codeine ___Others: _____

Do you use tobacco? __ No __ Yes / How used? _____ How much? _____ How long? _____

For Women: Are you taking Birth Control pills? ___ Y ___ N How many children have **you** had? _____

Are you pregnant? ___ N ___ Y / How long? _____ Are you nursing? ___ Y ___ N

Update

_____ ___/___/_____ _____
INITIALS DATE COMMENTS

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