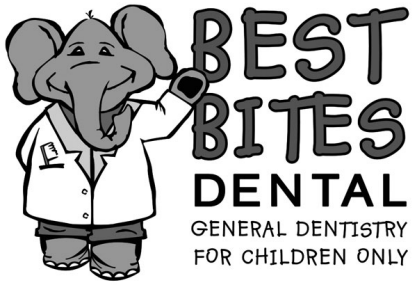

New Patient Information

First Name MI Last Name (Preferred Name)

Date of Birth Age M ☐ F ☐

How did you hear about us? _____

Your Address City State Zip Primary Phone Secondary Phone

Patient Health History

(Please answer ALL questions)

Heart Trouble	Yes ☐	No ☐	Pregnant	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Anemia	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐	Bleeding	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
HIV/AIDS	Yes ☐	No ☐	Allergies	Yes ☐	No ☐	Handicapped	Yes ☐	No ☐
Head Lice	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐	Prosthetic Joints or Pins	Yes ☐	No ☐
Liver/GI Disease	Yes ☐	No ☐	Lung/Breathing Disease	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	ADHD	Yes ☐	No ☐	Other:	Yes ☐	No ☐

If you answered "yes" to any of the above, please explain: _____

- Does the patient have any dental problems/concerns at this time? (check all that apply:) ✧ None
  ☐ Decay ☐ Pain ☐ Grinding ☐ Trauma ☐ Orthodontics ☐ Aesthetics ☐ Infection ☐ Other: _____
- Does the patient require antibiotics prior to dental treatment? Yes ☐ No ☐ If "yes", what type? _____
- Is the patient taking any medications at this time? Yes ☐ No ☐ If "yes", what type? _____
- Is the patient allergic to any medications/materials commonly used in a dental office (latex gloves, anesthesia)? Yes ☐ No ☐
  If "yes", what kind? _____

Parent/Guardian Information

Mother/Guardian Name Employer Father/Guardian Name Employer

Address City State Zip Phone # Work or Cell #

Nearest Relative not living w/Patient Relationship Phone #

* I understand I cannot leave the property while my child is being attended. If I leave, the proper authorities may be notified of my absence. I certify I have read and understand the above. I acknowledge my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other members of his/her staff, responsible for any errors or omissions I may have made in the completion of this form.

Parent/Guardian Signature **Date**