

# Brentwood Dental Excellence

## ❖ Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What do you preferred to be called: \_\_\_\_\_

Male  Female  Married  Single  Child  Other

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

Which of these numbers is the best to reach you during the day: HM WK CELL

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Does your immediate family have an established account with us:  yes  no

Name of person or other who referred you to our office: \_\_\_\_\_

## ❖ Health Information

When was your last dental Visit: \_\_\_\_\_

Main Reason for your Visit Today: \_\_\_\_\_

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

Aids	Allergies	Anemia	Arthritis	Artificial Joints	Asthma	Blood Disease
Cancer	Diabetes	Dizziness	Epilepsy	Excessive Bleeding	Fainting	Glaucoma
Growths	Hay Fever	Head Injuries	Heart Disease	Heart Murmur	Hepatitis	
High Blood Pressure	Jaundice	Kidney Disease	Liver Disease			
Mental Disorders	Nervous Disorders	Osteoporosis	Pacemaker	Radiation TX		
Respiratory Problems	Rheumatic Fever	Rheumatism	Sinus Problems			
Stomach Problems	Stroke	Tuberculosis	Tumors	Ulcers	Venereal Disease	Latex Allergy

Others Diseases/ Illnesses Not Listed: \_\_\_\_\_

**Are You ALLERGIC to any MEDICATIONS? If so, please list all:**

Are you required to take pre-medication for Dental Visits?  Yes  No

Please List Current Medication: \_\_\_\_\_

Have you ever had any complications following Dental Treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?

Yes  No If yes, please explain: \_\_\_\_\_

Are you now under the care of a Physician?  Yes  No If yes, please explain:

Do you have any health problems that need further clarification?

Name of your previous dentist: \_\_\_\_\_ Phone# \_\_\_\_\_

Name of your Physician: \_\_\_\_\_ Phone # \_\_\_\_\_