Halls Family Dentistry

Patient Name: ____ **Date:**____________

First *MI* *Last*

Preferred Name: ______________________________ **Date of Birth:** ____________

Social Security Number: __________________________ **Gender:** M F (*circle)*

Address: ____

Street

____

City State Zip Code

Email: _____________________________ **Phone:** ___________________________________

- ❏ AIDS
- ❏ Anemia
- ❏ Alcohol/Drug Abuse
- ❏ Arthritis
- ❏ Artificial Bones/Joints
  ____
  (what,when)
- ❏ Artificial Heart Valve
  ____
  (when)
- ❏ Asthma
- ❏ Blood Disease
- ❏ Cancer: *Type-*
  ____
- ❏ Cold Sores/Fever Blisters
- ❏ COPD
- ❏ Diabetes: *Type-*
  ____
- ❏ Dizziness / Fainting
- ❏ Epilepsy / Seizures
- ❏ Eating Disorder
- ❏ Excessive Bleeding
- ❏ Glaucoma
- ❏ Hay Fever
- ❏ Head Injury
- ❏ Headaches
- ❏ Heart Disease
- ❏ Heart Attack
- ❏ Heart Murmur
- ❏ Pacemaker
- ❏ Heart Surgery
- ❏ Mitral Valve Prolapse
- ❏ Congenital Heart Defect
- ❏ High Blood Pressure
- ❏ HPV
- ❏ Low Blood Pressure
- ❏ Hepatitis: *Type-*
  ____
- ❏ Jaundice
- ❏ Kidney Disease
- ❏ Liver Disease
- ❏ Mental Health Care
- ❏ Pregnancy (*currently)*
- ❏ Nursing (*currently)*
- ❏ Radiation/Chemotherapy
- ❏ Respiratory Problems
- ❏ Rheumatic Fever
- ❏ Sinus Problems
- ❏ Stomach Problems
- ❏ Stroke
- ❏ Thyroid Disorders
  - ❏ Hyperthyroid
  - ❏ Hypothyroid
- ❏ Tuberculosis
- ❏ Ulcers
- ❏ Other:
  ____
  ____
  ____
  ____
- ❏ Have you ever taken any osteoporosis medication?
  __ Yes __ No
- ❏ Are you required to take a premedication prior to dental appointment?
  __ Yes __ No

Please list ALL current medications: ____

____

____

Please list any allergies: ____

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

If yes, please specify: ____

Are you under the care of a physician? (*circle)* Yes or No

If yes, then please list their name: ____

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

Signature______________________________________ Date: ________________