

Please fill this out prior to your first visit at Forest Park Dental Arts

PATIENT INFORMATION

Today's Date _____/_____/_____

Patient _____
Last Name First Name M.I. Preferred Name

Address _____
City State Zip

Sex: Male or Female Age _____ Birth date ____/____/____ Single Married Widowed Divorced

Home Phone _____ Work _____ Cellular _____

Patient SS# ____/____/____ Occupation: _____ Employer _____

Employer address _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, give approximate dates _____

Have you ever had a blood transfusion? Yes No if yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Have you ever had any of the following disease or medical problems? Please mark Yes or No

Y N AIDS	Y N Cold sores/Fever Blisters	Y N Hepatitis	Y N Sinus Problems
Y N Anemia	Y N Cough Persistent	Y N High Blood Pressure	Y N Stroke
Y N Arthritis, Rheumatism Problems	Y N Congenital Heart Defect	Y N HIV Positive	Y N Thyroid
Y N Artificial Heart Valves	Y N Diabetes	Y N Jaw Pain	Y N Tobacco/Chew
Y N Artificial Joints	Y N Epilepsy	Y N Kidney Disease	Y N Tobacco/Smoke
Y N Asthma	Y N Fainting	Y N Liver Disease	Y N Tonsillitis
Y N Back Problems	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tuberculosis
Y N Blood Disease	Y N Headaches, severe	Y N Pacemaker	Y N Ulcer
Y N Cancer Disease	Y N Heart Murmur	Y N Psychiatric Care	Y N Venereal
Y N Chemical Dependency	Y N Heart Problems Describe _____	Y N Radiation Treatment	
Y N Chemotherapy	Y N Hemophilia	Y N Respiratory Disease	
Y N Circulatory Problem		Y N Rheumatic Fever	

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one:
