PATIENT INFORMATION

2901 Central Avenue
Homewood, AL 35209

Office 205.870.1363
www.centraldentistrypc.com

Name _____
Last First Middle Nickname

Address _____
Street Apt No. City State Zip Code

Previous Address (if less than 3 years) _____
Street Apt. No City State Zip Code

Sex: M F Birth Date ____/____/____ Social Security No ____/____/____ D.L. No. _____

Home Phone (____)_____Work Phone (____) _____ No. Years Employed____Marital Status ____

Employee_____ Occupation _____

Do you have dental insurance? Y N Insurance Company Name _____

Spouse's Name _____ Work Phone (____)_____

Spouse's Employer _____ Occupation _____

If patient is a minor, give parent or guardian's name _____

Is an immediate family member a patient here? Y N Name_____

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Self Y N Other _____
Last First Middle

If "Other" please complete:

Social Security No: ____/____/ _____ Birth Date ____/____/____ Relations to Patient _____

Address _____
Street Apt No. City State Zip Code

How long at this address_____ Home Phone (____)_____Work Phone (____)_____

Previous Address (if less than 3 years) _____
Street Apt. No City State Zip Code

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address _____
Street Apt No. City State Zip Code

Phone (____) _____

Name of Physician _____ Phone (____) _____

Address _____
Street Apt No. City State Zip Code

Over Please

HEALTH HISTORY	UPDATE									
(Confidential)	INITIALS									

Medical History

Date of last physical examination _____/____/_____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

(Women) Are you pregnant Y N Taking birth control pills? Y N

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cold Sores
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems (Describe _____)
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Swelling of Feet or Ankles
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other _____

Medications

1. _____ 3. _____
2. _____ 4. _____

Allergies

1. _____ 3. _____
2. _____ 4. _____

Dental History

Reason for today's visit _____

Date of last dental visit _____/_____/_____ Date of last dental X-ray films _____/_____/_____

Check (✓) if you have had problems with any of the following:

- ☐ Clicking or popping jaw
- ☐ Excessive bleeding after extractions
- ☐ Grinding your teeth
- ☐ Sores or growths in your mouth
- ☐ Undesirable reactions to anesthetics
- ☐ Undesirable reactions to nitrous

Check (✓) the following that are most important to you:

- ☐ Ability to chew your food
- ☐ Appearance, color of teeth
- ☐ Prevention of dental problems and gum disease
- ☐ Saving your teeth as long as possible
- ☐ Replacing missing teeth with fixed or removable bridgework

Do you have any reluctance to having dentistry done? Y N

If so, why? _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____