ALABAMA FAMILY DENTISTRY
PATIENT INFORMATION

Patient Name:_____ Date:_____

❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Other

Social Security #:_____ Date of Birth:_____ Age:_____

Phone (Home):(___) _____ (Work):(___) _____ Ext:_____ Cell:(___) _____

Driver's license #:_____

Address:_____ Apartment#:_____

City:_____ State:_____ Zip:_____

Emergency Contact_____ Phone:_____

HEALTH INFORMATION

Date of Last Dental Visit:_____ Reason for this visit:_____

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

❑ AIDS
❑ Allergies_____
❑ Aortic Valve Regurgitation
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Asthma
❑ Blood Transfusion
❑ Birth Control
❑ Cancer
❑ Codeine Allergy
❑ Diabetes
❑ Dizziness
❑ Alcohol Addiction
❑ Drug Addiction
❑ Epilepsy
❑ Fainting
❑ Fever Blisters
❑ Glaucoma
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
Type_____
❑ High Blood Pressure
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Mouth Ulcers
❑ Nervous Disorders
❑ Pacemaker
❑ Penicillin Allergy
❑ Pregnancy
Due Date:_____
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Rheumatism
❑ Sinus Problems
❑ Stomach Ulcers
❑ Stroke
❑ Sulfur Allergy
❑ Tuberculosis
❑ Ulcers
❑ Using Blood Thinner
❑ Using Methadone
❑ Viagra Type Med.
❑ Venereal Disease
OTHER
❑ _____

- 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:_____
- Name of Physician:_____ Phone:_____
- Do you have any health problems that need further clarification? ❑ Yes ❑ No
  If yes, please explain:_____
- What medications are you currently taking, including over the counter and herbal medications ?_____

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

_____

_____ Date:_____

Signature of patient or guardian

Referral Information

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative

❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other _____

Name of person or office referring you to our practice:_____