# CREEKSIDE DENTAL

## PERSONAL INFORMATION

Patient Name _____ Birth date _____/_____/_____

If patient is a minor, parent/guardian name _____

Address _____
City State Zip

Phone: Home _____ Cell _____ Work _____

Email _____ Personal / Work (circle one)

How long has it been since your last visit to the dentist? _____ Where? _____

**Contact Preferences** (please circle all that apply):
Home phone Cell phone Work phone Email Text (**service provider** _____)

## MEDICAL HISTORY

Are you presently in good health? Yes No If no, please explain _____
Are you currently under a physician's care (other than regular check ups)? Yes No If yes, please explain _____
Have you ever had a serious illness or injury? Yes No If yes, please explain _____
Are you on a special diet or have any dietary restrictions? Yes No If yes, please explain _____
Do you use tobacco in any form? Yes No

What drugs or medications are you currently taking?_____

**Are you allergic to any of the following?**
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other - Please explain: _____

**Have you had or do you have any of the following?** (please circle all that apply)

| | | | |
|---|---|---|---|
| AIDS/HIV | Heart Murmur/Problems | Rheumatic Fever | Glaucoma |
| Bleeding disorder | Hepatitis | Rheumatism | Heart Attack/Stroke/Pacemaker |
| Cancer/Tumors | High Blood Pressure | Stomach/Intestinal disorders | Lung or breathing problems |
| Convulsions/Seizures | Lasik | Tuberculosis | Prosthetic/Artificial joints |
| Diabetes | Liver problems | Thyroid disorders | Other _____ |

**Women Only:**
Are you pregnant? _____ Due date _____ Nursing? _____ Menstrual disorders? _____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my/patient's health. It is my responsibility to inform the dental office of any changes in medical status.**

****SIGNATURE _____ Date _____**
Patient, Parent or Guardian