

GREATER LAS VEGAS DENTAL

Patient Information Patient Name: _____ Date: _____
Last First MI

Address: _____
Street Apartment #

_____ City _____ State _____ Zip Code _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Drivers License#: _____

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

Email: _____ Email & Text messaging confirmation available : Please circle one YES or NO

Health Information

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

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

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy |
| | <input type="checkbox"/> Growths | Due date: _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophelia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mitro Valve Prolapse_ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Codeine Allergy |

- Penicillin Allergy
 OTHER: HIV
 Hepatitis _____

Medications Currently Taking

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY NAME _____

Phone # _____

- 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: _____

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.

 Signature of patient, parent or guardian Date: _____

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: _____