Patient Information

Patient Name: _____
Last Name First Name MI Preferred Name

Email Address: _____ Best way to reach you? ☐Phone ☐Email ☐Text

Social Security #: _____ Birthdate: _____ Gender: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Address: _____, _____
Street City State Zip

Health Information

Date of last dental visit: _____ Reason for visit: _____

Have you ever had or currently have any of the following? Please check all that apply:

☐ Anesthetic Allergy
☐ Penicillin Allergy
☐ Codeine Allergy
☐ Ibuprofen Allergy
☐ Other Allergies (list):

☐ Arthritis
☐ Artificial Joints:
Date & Joint Replaced:

☐ Asthma

☐ Back/Neck Problems
☐ Taking Bisphosphates
☐ Taking Blood Thinners
☐ Cancer
☐ Crohn's
☐ COPD
☐ Depression/Anxiety
☐ Diabetes
☐ Fibromyalgia
☐ GERD
☐ Glaucoma
☐ Head Injuries
☐ Heart Attack
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease

☐ Lupus
☐ Mental Health Issues
☐ Migraines
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pregnancy
Due Date:
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Seizure Disorder
☐ Sinus Problems
☐ Sleep Apnea
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disorder - hypo
☐ Thyroid Disorder - hyper
☐ TMJ/TMD
☐ Tuberculosis

☐ Ulcers
☐ Ulcerative Colitis
☐ Tobacco Use?
Type & Amount/day:

☐ Recreational Drug Use?
Type(s) and Most Recent Dates of Use:

☐ Other Health History:

LIST ALL MEDICATIONS:

☐Y ☐N - Have you ever had any complications following dental treatment? If yes, please describe:

☐Y ☐N - Have you been admitted to a hospital or needed emergency care during the past two years? If yes, please describe:

☐Y ☐N - Have you been under the care of a physician for a medical condition (within the past year)? If yes, please describe:
Name of Physician:

☐Y ☐N - Do you have any health problems that need further clarification? If yes, please describe:

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 Dr. Yarbro at my next appointment without fail. I also verify that all information pre-printed on this form is correct.

_____
Signature of patient or legal guardian Date

Referral Information

How did you hear about our office and/or whom may we thank?

Notes (Office Use Only):