Ferguson family dental

PATIENT INFORMATION

NAME (Last, First Middle): _____

ADDRESS: _____

PREFERRED NAME: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____ SEX: _____

CELL PHONE: _____ OTHER PHONE: _____

EMAIL: _____

HOW DID YOU FIND US? _____

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM: _____/_____/_____

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYSICIAN'S CARE?

IF SO, PLEASE EXPLAIN: _____

_____

HAVE YOU EVER BEEN A PATIENT IN A HOSPITAL OR HAD ANY SERIOUS ILLNESS?

IF SO, PLEASE EXPLAIN: _____

_____

_____

PLEASE CONTINUE TO NEXT PAGE...

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CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR SUSPECTED HAVING:

	Arthritis		Hepatitis or Jaundice		Prolonged Bleeding
	Rheumatic Fever		Liver Disease		Fainting Tendency
	Heart Trouble		Cancer or Tumor		Epilepsy
	Heart Murmur		Tuberculosis		Thyroid Disease
	High/Low Blood Pressure		Diabetes		Glaucoma
	Chest Pain		Kidney/Bladder Trouble		Radiation Treatment
	Stroke		Anemia		Mental Disorders
	Shortness of Breath		Lung Disease		HIV or AIDS
	Asthma or Hay Fever		Venereal Disease		Prosthetic Joint Replacement
	Sinus Trouble		Blood Disease		Blood Transfusion

PLEASE EXPLAIN IF NEEDED: _____

_____

ARE YOU TAKING OR HAVE YOU TAKEN:

YES	NO		YES	NO		YES	NO	
		Cortisone Drugs			Anticoagulants			Tranquilizers
		Steroids			Blood Thinners			Sedatives

ARE YOU TAKING ANY OTHER MEDICATIONS? IF SO, PLEASE LIST: _____

_____

PLEASE CONTINUE TO FINAL PAGE...

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ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
		Penicillin			Codeine			Dental Anesthesia
		Aspirin			Household Bleach			

DO YOU HAVE ANY OTHER KNOWN ALLERGIES? IF SO, PLEASE LIST: _____

_____

WOMEN ONLY:

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS? _____

ARE YOU BREAST FEEDING? _____

ARE YOU PRESENTLY TAKING MEDICINE OF ANY KIND ROUTINELY? (i.e. birth control pills, shots or implant, hormone therapy, etc.) IF SO, PLEASE LIST: _____

_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT (PARENT/GUARDIAN) SIGNATURE: _____

DATE: _____