Hudson View Dental

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Personal Information:

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female ◯ Other **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* _____ _____ ____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____* _____
Address 1 Address 2

_____* ____* _____-____*
City State Zip Code

Who is your emergency contact? Please list their name, phone number, and relationship to you.

_____

_____

Is there anyone you authorize our office to speak with regarding your dental health care? If so; please list their name, phone number, and relationship to you.

_____

_____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response. If "YES" please describe below

☐ *PRE-MED*	☐ Metal Implants	☐ Cancer	☐ Clotting Disorders	☐ Head Injuries
☐ Epinephrine Sensitivity	☐ Artificial Joints	☐ Epilepsy	☐ Excessive Bleeding	☐ Diabetes
☐ Latex Allergy	☐ Artificial Heart Valves	☐ Anemia	☐ HIV	☐ Asthma
☐ Narcotic Allergy	☐ Glaucoma	☐ High Blood Pressure	☐ Heart Murmur	☐ Gastric Disorders
☐ Amox/Penicillin Allergy	☐ Stomach Problems	☐ Low Blood Pressure	☐ Hepatitis	☐ Heart Disease
☐ Chronic Headaches	☐ Fainting	☐ Mitral Valve Prolapse	☐ Hypothyroid	☐ Liver Disease
☐ Mental Disorders	☐ High Cholesterol	☐ Ostheoporosis	☐ Hyperthyroid	☐ Kidney Disease
☐ Respiratory Issues	☐ Pacemaker	☐ Rheumatism	☐ Sinus Problems	☐ Radiation Treatment
☐ Tumors	☐ Stroke	☐ Vertigo (Dizziness)	☐ Tuberculosis	☐ Other (specify below)

If any of the conditions or alerts selected need further clarification, please describe below:

_____

_____

To your knowledge, are you allergic to any medications? * ◯ Yes ◯ No

If "YES" please list medication allergies:

Are you required to take an antibiotic pre-medication for your dental visits as ordered by a physician due to past surgery or medical condition? *

◯ Yes ◯ No

If "YES" please explain why below and list the instructions for use as provided by your physician:

Are you actively under the care of a doctor for any medical conditions, have any impending surgery, or other treatment that may possibly affect your dental treatment?

Physician Name and Phone Number

Are you currently pregnant? *

◯ Yes ◯ No ◯ N/A

If "YES", how many weeks? _____

Do you take aspirin or blood thinners? ◯ Yes ◯ No

List all medications (prescription, non-prescription and/or supplements) including regular doses of aspirin:

Name and Phone Number of Preferred Pharmacy

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

☐ **By checking this box and signing below, I acknowledge that I have read, completed the above information and agree to the contents.**

Signature _____ **Date** _____

Response Date: _____