## Patient Information

**Patient Name: _____ Date: _____**

**Social Security #_____ Birth Date_____ Phone #_____**

**Email Address: _____ Cell #_____**

**Address: _____ Apartment: _____**

**City: _____ State_____Zip Code: _____**

## Health Information

**Date of Last dental Visit: _____ Reason for This Visit: _____**

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

| | | | |
|---|---|---|---|
| □AIDS | □Excessive bleeding | □Liver Disease | □Stroke |
| □Allergies: _____ | □Fainting | □Mental Disorders | □Tuberculosis |
| | □Glaucoma | □Nervous Disorders | □Tumors |
| □Anemia | □Growths | □Pacemaker | □Ulcers |
| □Arthritis | □Hay Fever | □Pregnancy | □Venereal Disease |
| □Artificial Joints | □Head Injuries | Due Date: _____ | □Codeine Allergy |
| □Asthma | □Heart Disease | □Radiation Treatment | □Penicillin Allergy |
| □Blood Disease | □Heart Murmur | □Respiratory Problems | □Other: |
| □Cancer | □Hepatitis | □Rheumatic Fever | _____ |
| □Diabetes | □High Blood Pressure | □Rheumatism | _____ |
| □Dizziness | □Jaundice | □Sinus Problems | _____ |
| □Epilepsy | □Kidney Disease | □Stomach Problems | _____ |

**- Have you ever had any complications following dental treatment? ____ Yes ____ No**

**If yes, please explain_____**

**-Have you been admitted to the hospital or needed emergency care during the past two years? ____Yes ____No**

**If yes, please explain_____**

**-Are you taking birth control pills at this time? ____Yes ____No**

*** * The effectiveness of the contraceptive may be reduced in combination with antibiotics****

**-Are you now under the care of a physician? ____Yes ____No**

**If yes, please explain_____**

**-Name of Physician: _____ Phone#_____**

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.**

**Signature: _____ Date: _____**
**Dr. Signature: _____**

**MODEL RELEASE**

**I hereby give permission to Apple Dental Center to use my photo\ video for media, advertising, and any other lawful purpose.**
**Print Name:_____ Signature:_____ Date:_____**

**SINCE MY LAST MEDICAL UPDATE, THERE ARE NO CHANGES IN MY MEDICAL HISTORY. □**

**Signature: _____ Date: _____**

**Dr. Signature: _____**