

Cascade Periodontics

PATIENT INFORMATION

Patient name: _____ Date: _____

(Last) (First) (MI)
 Male Female Married Single Child Other

Social Security #: _____ - _____ - _____ Date of birth: _____ Best time to call: _____

Phone: (home) _____ (work) _____ (cell) _____

E-mail address: _____ High speed Dial up

Preferred appointment times: Morning Afternoon Any time M T W TH

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

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

HEALTH INFORMATION

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

- | | | | |
|---|---|--|-------------------------------------|
| <input type="radio"/> AIDS | <input type="radio"/> Excessive bleeding | <input type="radio"/> Penicillin allergy | <input type="radio"/> Stroke |
| <input type="radio"/> Allergies _____ | <input type="radio"/> Fainting | <input type="radio"/> Codeine allergy | <input type="radio"/> Tuberculosis |
| <input type="radio"/> _____ | <input type="radio"/> Glaucoma | <input type="radio"/> Drug allergies _____ | <input type="radio"/> Tumor |
| <input type="radio"/> Anemia | <input type="radio"/> Aspirin allergy | <input type="radio"/> _____ | <input type="radio"/> Ulcers |
| <input type="radio"/> Arthritis | <input type="radio"/> Hay fever | <input type="radio"/> Pregnancy due date | <input type="radio"/> Herpes |
| <input type="radio"/> Artificial joints | <input type="radio"/> Head injuries | <input type="radio"/> _____ | <input type="radio"/> Pacemaker |
| <input type="radio"/> Asthma | <input type="radio"/> Heart disease | <input type="radio"/> Radiation treatment | <input type="radio"/> Liver disease |
| <input type="radio"/> Blood disease | <input type="radio"/> Heart murmur | <input type="radio"/> Respiratory problems | <input type="radio"/> Other: _____ |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis | <input type="radio"/> Rheumatic fever | <input type="radio"/> _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> High blood pressure | <input type="radio"/> Rheumatism | <input type="radio"/> Tobacco usage |
| <input type="radio"/> Dizziness | <input type="radio"/> Jaundice | <input type="radio"/> Sinus problems | |
| <input type="radio"/> Epilepsy | <input type="radio"/> Kidney disease | <input type="radio"/> Stomach problems | |

* Do you take any over the counter or prescription medications: Yes No

If yes, please list: _____

* Do you currently take vitamin E, a multi-vitamin, or any aspirin based products on a regular basis?

Yes No If yes, please list: _____

* Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

* Are you under the care of a physician? 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 doctor at the next appointment without fail.

Signature of patient, parent or guardian

Date