

Welcome to Serene Dental

Patient information

Name _____ E-Mail _____

D.O.B. _____ SS# _____ Home Ph # _____ Work/cell # _____

Address _____

city _____ state _____ zip _____

Sex: M / F Family status: _____ Emergency contact name and ph# _____

Responsible party

Responsible person for account _____ Relation to patient _____

SS# _____ Phone# _____ Driver license# _____

Health history

Family physician: _____ Ph# _____

Are you currently taking any medications? YES NO
If so for what? _____

Have you been under care by a physician during the last two years and for what? YES NO
If so for what? _____

Are you taking or have ever taken any osteoporosis medications? _____ YES NO

Check if you have or had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Fen-phen |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney disease/transplants |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Cancer/radiation/chemotherapy |
| <input type="checkbox"/> Artificial heart valves/joints, implants etc | <input type="checkbox"/> Asthma/lung disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy/psychiatric problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Other conditions |
| <input type="checkbox"/> Bleeding disorders | |

Do you have any allergies to any medications: _____ YES NO If so what? _____

Do you have or had any disease or condition not listed above? YES NO
If so, what? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have change in health. Should further information be needed, you have my permission to request my health care provider to release the information to you. Further, I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/parent/Legal guardian signature

Date

Recall Signature	Date	Recall Signature	Date
Recall Signature	Date	Recall Signature	Date
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