CONFIDENTIAL PATIENT INFORMATION

*Please Print*

Patient Name:_____________________________________________Date of Birth: _____________________

Nickname: __________________________Male___ Female___ If Female, are you pregnant? Yes___ No___

If Patient is a minor, Parent or Guardian:___________________________________________________

Home Phone: ___________________ Mailing Address: ____________________________________________

*street*

Cell Phone: _____________________ ____________________________________________

*city / state / zip*

Work Phone: ____________________ Email Address: ____________________________________________

Place of Employment:______________________________Occupation:______________________________

Marital Status: _________________ If married, Spouse Name: ____________________________________

Dental Insurance? Yes___ No___ If Yes, Insurance Company Name: ________________________________

SS#/ID#:______________________ Group#: _____________________ Phone#:______________________

Oral Health: Excellent___ Good___ Fair___ Poor___ Medical Health: Excellent___ Good___ Fair___ Poor___

Physician's Name__________________________________________Last physical? ____________________

Do you have any dental anxiety? Yes___ No___ Are you subject to prolonged bleeding? Yes___ No___

Have you ever received a blood transfusion? Yes___ No___ When? _________________________________

Have you ever used tobacco products? Yes___ No___ If Yes, do you currently? Yes___ No___ Qty?________

Are you allergic to: Penicillin___ Codeine___ Local anesthetics___ Other ____________________________

Please list any medications, pills or drugs you are taking:____________________________________________

______________________________________________________________________________________

Please circle if you have or have had any of the following:

| | | | |
|---|---|---|---|
| **High Blood Pressure** | Low Blood Pressure | Heart Murmur | Mitral Valve Prolapse |
| **Artificial Heart Valve** | Congenital Heart Lesion | Heart Surgery | Hemophilia |
| **Pacemaker** | Blood Disease | Stroke | HIV |
| **Heart Trouble** | Chest Pain | Anemia | Thyroid Disease |
| **Hepatitis** | Kidney Disease | Ulcers | Liver Disease |
| **Diabetes** | Hypoglycemic | Glaucoma | Psychiatric Care |
| **Allergies** | Emphysema | Sinus Trouble | Shortness of Breath |
| **Cancer** | Lung Disease | Asthma | Rheumatic Fever |
| **Chemo/Radiation** | Recent weight loss | Epilepsy | Fainting |
| **Artificial Joints/Hips** | Alzheimer's | Arthritis/Gout | Swelling/Feet/Ankles/Hands |

Please describe in detail any serious illness not listed above:______________________________________

______________________________________________________________________________________

I allow Dr. Stephens permission to discuss my conditions with my physician and to request medical information from him or her when necessary.

Patient's Signature:______________________________________________Date:____________________

If Patient is a minor, Signature of Parent or Guardian: ____________________________________________