Welcome to Dublin Ranch 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:

Yes	No		Yes	No	
❑	❑	Heart problems	❑	❑	Fen-phen
❑	❑	Heart murmur	❑	❑	Kidney disease/transplants
❑	❑	Mitral valve prolapse	❑	❑	Cancer/radiation/chemotherapy
❑	❑	Artificial heart valves/joints, implants etc	❑	❑	Asthma/lung disease
❑	❑	Rheumatic fever	❑	❑	Epilepsy/psychiatric problems
❑	❑	Pacemaker	❑	❑	Latex allergy
❑	❑	Stroke	❑	❑	Smoke
❑	❑	High blood pressure	❑	❑	Sexually transmitted disease
❑	❑	Diabetes	❑	❑	Pregnant
❑	❑	Liver disease/hepatitis	❑	❑	Nursing
❑	❑	Aids/HIV	❑	❑	Other conditions
❑	❑	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**