North Rivers Dental Associates

Patient Information

Patient Name: _____ Date: _____
First MI Last (Preferred Name)

☐Male ☐ Female ☐ Married ☐ Single ☐Child ☐ Other

Social Security #: *(Adults Only)*_____ Birth Date: _____

Email Address: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

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

- ☐ **Aids/HIV**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial joints/ Hip or Knee**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Congenital Heart Lesions**
- ☐ **Diabetes**
- ☐ **Epilepsy/Seizures**
- ☐ **Excessive bleeding**
- ☐ **Fainting or Dizziness**
- ☐ **Fosamax/Boniva**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis (Type___)**
- ☐ **High Blood Pressure**
- ☐ **Jaw Pain**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Mental Disorder**
- ☐ **Mitral Valve Prolapse**
- ☐ **Nervous/anxiety disorder**
- ☐ **Pacemaker**
- ☐ **Plavix/Coumadin**
- ☐ **Pregnant Due Date:**
- ☐ **Radiation Treatment**
- ☐ **Rheumatic fever**
- ☐ **Sexually Transmitted Disease**
- ☐ **Stroke**
- ☐ **Thyroid**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **DO YOU TAKE ASPIRIN DAILY?**
- ☐ **List all medicines taken:**

_____
_____
_____
_____

ALLERGIES:

- ☐ **Aspirin Allergy**
- ☐ **Codeine Allergy**
- ☐ **Iodine Allergy**
- ☐ **Latex Allergy**
- ☐ **Local Anesthetics Allergy**
- ☐ **Penicillin Allergy**
- ☐ **Sulfa Allergy**
- ☐ **Other Allergies**_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Emergency Contact: _____ Phone:_____
- **Whom may we thank for referring you to our office**?_____

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 doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian