Chart #: ________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________ Date: __________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

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

- ☐ Medication Allergies:
  ____
  ____
  ____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Sensitivity
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Sinus Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: __________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ AIDS/HIV

OTHER:
- ☐ ________________
- ☐ ________________

____

- 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: ____
- Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- **Please list ALL medications you are currently taking:** (such as drugs, pills, and herbal remedies)

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

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

______________________________ Date: ______________
Mark S. Givan, D.D.S.