Butler Hill Dental

Patient Information Date _____

Name – Last _____ First _____ MI ___ Preferred _____
Birth date_____ Male___ Female___ Child___ Single___ Married___ Separated___ Divorced___ Widowed___
Social Security # _____ E-Mail _____
Cell# _____ Home# _____ Work# _____ Ext _____
Mailing Address – Street _____
Apt# _____ City _____ State _____ Zip Code _____

Health Information

Date of last dental visit _____ Previous Dentist _____ Reason for visit_____
Have you ever had any of the following? Please circle all that apply:

AIDS/HIV	Venereal Disease	Hepatitis A B C	Blood Disease
Pacemaker	Heart Disease	Heart Murmer	Mitral Valve Prolapse
Stomach Problems	Ulcers	Anemia	Acid Reflux
Rheumatic Fever	Arthritis	High Blood Pressure	Diet Pills
Asthma	Head Injuries	Kidney Disease	Diabetes
Cancer	Tumors	Growths	Radiation Treatment
Dizziness	Fainting	Epilepsy	Respiratory Problems
Osteoporosis	Excessive Bleeding	Stroke	Hay Fever
Sinus Problems	Tuberculosis	Glaucoma	Liver Disease
Multiple Sclerosis	Jaundice	Nervous Disorders	Mental Disorders
Lupus	Periodontal/gum disease	Pregnancy – Due date _____	

Other conditions _____

Weight Loss Surgery/Date _____ **Artificial Joints-Date/Type** _____
Allergies – Codeine Penicillin Sulfa Keflex Latex Other _____
Medications _____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? _____
If yes, please explain _____
Primary care physician _____ Phone # _____
Specialist physician _____ Phone # _____
Are you currently taking bisphosphonates for osteoporosis, breast cancer, prostate cancer or multiple myeloma? _____
If female, are you taking birth control pills? _____ If yes, antibiotic therapy may render your birth control ineffective.
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. I also understand this needs to be updated once a year.

There is a charge for missed or cancelled appointments without a 24 hour advance notice. After 3 appointments missed or cancelled without a 24 hour notice, we will no longer be able to see you as a patient.

_____ _____
Signature of patient, parent or legal guardian Date

Referral Information – Whom may we thank for referring you to our practice? Another patient/friend/relative Dental office Work Facebook Name of person or referring office? _____