

NEW PATIENT DATA

PLEASE PRINT

PATIENT INFORMATION

Full Name (include middle) _____

Date of Birth _____ Age _____ Sex M _____ F _____

Name of parent or guardian (if patient is a minor) _____

Relationship of patient and guardian _____

Home Address _____

City, State, Zip _____

Home Phone _____ Cell _____ Work _____

Email Address _____

Employer _____ Occupation _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Number of Children: Boys _____ Girls _____

Name of Spouse _____

Spouse's Employer _____ Occupation _____

EMERGENCY INFORMATION

Contact in Emergency _____ Relationship _____

Phone _____

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

How did you hear about us? Referred by _____

REASON FOR FIRST VISIT

Chief complaint, please describe fully _____

Duration of present condition _____

What do you believe caused this condition? _____

Diagnosis by your doctor (if available) _____

Dental History:

Have you had, or do you have:

Braces _____ Bridges _____ Cavities _____

Gum Work _____ Oral Surgeries _____ Root Canals _____

Teeth Replaced _____ TMJ Problems _____

Fillings _____ If yes, at what age did you first get fillings? _____

Any fillings taken out _____

Crowns _____ If yes, what are they made of (procelain / gold/ etc)? _____

Other information _____

Present / Past History:

Any history of **anaphylactic** reactions? _____

If yes, what did you react to? _____

Have you been allergy tested? _____ List any **known allergies** _____

List all foods and beverages you **crave** (or eat more than 3 times weekly): _____

Have you or do you now have any **Pets**? _____ Kind? _____

Have you had any **tick bites** or reaction to **insects**? _____

Have you **traveled** to other countries? (Names) _____

Have you ever had **food poisoning**? _____

Do you have a **swamp cooler** or **refrigerated air**? _____

Have you or are you now, living near or on a **farm** or near **crop spraying**? _____

Have you or are you now, living near **microwave towers** or **toxic dumps**? _____

Do you take **vitamins**? _____ List names: _____

List any **medications** you are taking now: _____

Have you taken any **casual drugs** now or in the past? _____ If yes how many years and what kind(s)? _____

Have you ever **smoked**? _____ How many per day? _____ Currently smoke? _____

Do you drink **alcohol**? _____ regularly _____ seldom _____ # per day _____

Do you drink **coffee**? _____ How much? _____

Do you **exercise**? _____ regularly _____ seldom _____ type? _____

Hobbies (if any): _____

Exposure to environmental **toxic substances** through employment, hobbies, etc.? _____

List any **hospitalization(s)**: _____

Have you had any previous/current **back troubles**? _____ Describe _____

Any aggressive behaviors/ depression/ emotional imbalances, past or present: _____

Other _____

Physical Trauma:

Have you had any:

Birth trauma _____ Bicycle falls/accidents _____ Car accidents _____

Head trauma _____ Highchair falls _____ Hit by any balls _____

Monkey-bars fall _____ Skateboarding falls _____ Tree falls _____

Other (List any other trauma/ significant injuries as is slips, falls, any fall involving the head, etc)?

Please explain: _____

Vaccination History:

Were you vaccinated as a child? _____ If yes, which vaccines have you had:

MMR (Measles, Mumps, Rubella) _____

Polio Vaccine _____ DtaP _____ Hib Vaccine _____ HBV _____

Varicella Vaccine _____ PCV7 _____ Diphtheria _____ DPT _____

Infuenza _____

Other _____

Vaccination reaction(s)? _____

(Please include a copy of vaccination records, if possible)

Personal History

Childhood Information & Past History: (please check or specify as appropriate)

Abdominal pain _____	ADD/ADHD _____	Alcoholism _____
Allergies _____	Allergy Shots _____	Anemia _____
Anorexia _____	Appendicitis _____	Arthritis _____
Asthma _____	Autism _____	Bleeding disorder _____
Blood clots _____	Breast lumps _____	Blood pressure: high _____ low _____
Bronchitis _____	Bulimia _____	Cancer _____
Cataracts _____	Chemical dependency _____	
Chicken Pox _____	Cholesterol: high _____ low _____	Chronic fatigue _____
Colic _____	Congenital problems _____	Dental problems _____
Deviated Septum _____	Diabetes _____	Diverticulitis _____
Dyslexia _____	Ear aches _____	Emphysema _____
Epilepsy _____	Fatigue _____	Food sensitivity _____
Fractures _____	Glaucoma _____	Goiter _____
Gout _____	Hay fever _____	Headaches _____
Hernia _____	Herniated Disc _____	Herpes _____
High temps _____	HIV (Aids) _____	Hyper activity _____
Hypertension _____	Hypoglycemia _____	Irritable Bowel _____
Kidney disease _____	Learning differences _____	Liver disease _____
Lung disease _____	Lyme disease _____	Measles _____
Migraine headaches _____	Miscarriage _____	Mononucleosis _____
Mental/Emotional problems _____		Multiple Sclerosis _____
Osteoporosis _____	Mumps _____	Nervous Breakdown _____
Pacemaker _____	Parkinson's disease _____	Pinched nerve _____
Polio _____	Pneumonia _____	Prostrate problems _____
Psychiatric care _____	Rheumatic Fever _____	Rheumatoid Arthritis _____
RSV _____	Scarlet Fever _____	Sexual problems _____
Skin Dermatitis _____	Strep _____	Stroke _____
Thyroid problems _____	Tonsillitis _____	Tuberculosis _____
Tumor growths _____	Ulcers _____	Weight: over _____ under _____

Whooping Cough _____
List any significant illness: _____

Any unusual diseases? _____

List any surgeries or operations: _____
