

Patient Information

Patient Name: _____ Date: _____
Title Last First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Birth Date: _____ Driver's License No. _____ Social Security #: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Email: _____
 Fax: _____ Pager: _____ Other: _____
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Reason for this visit: _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| | <input type="checkbox"/> Hay Fever | Due date: _____ | <input type="checkbox"/> Taken Phen-fen |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Taken Redux |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral-Valve Prolapse | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease | |

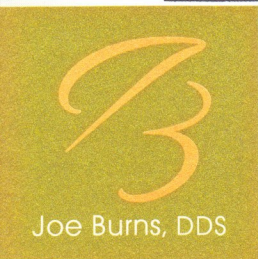
- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Please list any medication that you are currently taking: _____

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.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Name of person or office referring you to our practice: _____



Enhancing the Smile in You

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