LADUE
FAMILY DENTAL

Chart #:_____
FOR OFFICE USE ONLY

Patient Information

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

Social Security #: _____ Gender: _____ Birth Date: _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T

Address: _____

City _____ State _____ Zip Code _____

Email: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- ☐ AIDS/HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Auto Immune Disease
- ☐ Asthma
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Transfusion Date_____
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis_____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers/Colitis
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER:
- ☐ _____
- ☐ _____

WOMEN:

- ☐ Pregnancy Due Date_____
- ☐ Nursing
- ☐ Birth Control Pills/Shot

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Please list all medications you are currently taking, including over the counter drugs_____
_____

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: _____

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

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient or Friend _____

☐ Dental Office ☐ Internet ☐ Newspaper ☐ School ☐ Work ☐ Other _____