SEQUOIA FAMILY DENTAL

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient name _____ Preferred name _____ Birth date_____

If minor, parents' names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ SSN _____ Email _____

Do you have / have you had any of the following?
(Please check any that apply)

- ❑ Anemia
- ❑ Anxiety/depression
- ❑ Arthritis
- ❑ Artificial joints
  Date of surgery:
- ❑ Asthma
- ❑ Auto-immune disorders
- ❑ Blood disorders
- ❑ Cancer
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Congenital heart lesions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Headaches/migraines
- ❑ Head injuries
- ❑ Heart condition or disease
- ❑ Heart murmur
- ❑ Heart surgeries
- ❑ Mitral valve prolapse
- ❑ Hepatitis A / B / C
- ❑ Herpes/cold sores
- ❑ High cholesterol
- ❑ HIV/AIDS
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Latex allergy
- ❑ Liver disease
- ❑ Low or high blood pressure
- ❑ Lyme disease
- ❑ Pacemaker
- ❑ Pregnant (currently)
  Due date:
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory problems
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Sinus problems
- ❑ Stroke
- ❑ Surgeries requiring pins/screws/plates
- ❑ Thyroid conditions
- ❑ Tuberculosis
- ❑ Tobacco use
- ❑ Ulcers
- ❑ Visually or hearing impaired

Name of physician _____ Phone number _____

Address _____ Last exam date _____

Allergies _____

Major operations _____

Medications (prescriptions, over the counter, herbal supplements, etc.) _____

_____

Do you require antibiotic premedication prior to dental treatment? _____ Yes _____ No

Do you have any disease, condition, or problem not listed above? _____ Yes _____No

If yes, please explain: _____

_____

_____ _____
Signature of patient, parent, or guardian Date

_____ RDH / DMD _____
Reviewed by Date