



Dental Clinic
 For Front Office Use Only
 STUDENT CLINICIAN _____ DH DA
 UNIT _____

APPT. DATE AND TIME

Patient Personal Information & Medical History

Today's Date _____

Name _____ DOB _____ M ___ F ___

Address _____

City _____ State _____ ZIP _____

Home Phone _____

Cell Phone _____

Emergency Contact Name _____

Relationship _____

Phone Number _____

Physician's Name _____

Address _____

Phone Number _____

Dentist's Name _____

Address _____

Phone Number _____

Date of last dental exam _____

Date of last dental hygiene treatment _____

Date of last dental panoramic x ray _____

Date of last dental panoramic x ray _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No. If yes, please explain:

Have you ever had a serious head or neck injury? Yes No. If yes, please explain: