Kidwell & Albus
Preventive and Restorative Dentistry

Patient Information and Health History

Name: _____Male/Female Married/Single/Child

Spouse _____

Date:_____ Birthdate:_____ Referred By:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Home:_____ Cell:_____ Work:_____

Employer:_____ Occupation:_____

Email:_____ May we contact you via email? YES NO

Do you have dental insurance? _____ If so, who is the primary subscriber?_____

Are you experiencing a dental problem at this time? _____
_____

Emergency Contact Name:_____Number:_____

Physician's Name:_____ Phone:_____

Please check any of the following, which you have at the present time:

Artificial Joint_____Date:_____	Tuberculosis_____	Diabetes_____
Auto Immune Disorder_____	Epilepsy_____	Anemia_____
Infectious Hepatitis_____	Heart Trouble_____	Asthma_____
Kidney/Liver Disease_____	Hypertension_____	Cancer_____
Taking Bisphosphonate_____	Artificial Heart Valve_____	HIV_____
Taking Blood Thinner_____	Tobacco Use_____	Pregnant_____

List all medications and doses. Please explain any of the above or any additional medical conditions.
_____
_____
_____
_____
_____
_____

Do you need to be premedicated with an antibiotic for dental appointments? YES NO

Are you allergic to any medications?_____ If so, please specify_____

Signature: _____