Patient Health History

Please fill out completely

Patient's Name: _____

Address: _____

_____

Phone: _____

Email address: _____

Parent's Name: #1 _____

#2 _____

General Dentist _____ Phone#: _____

Does the patient have any allergies? ☐ Yes ☐ No

If yes, please list: _____

Is the patient taking any medications? ☐ Yes ☐ No

_____

Any chance the patient is pregnant? ☐ Yes ☐ No

Any changes in the patient's medical history: ☐ Yes ☐ No

_____

_____ _____ _____

Patient or Guardian Signature Date Staff signature

Appointment form given: Date: