Isla Dental

201 S Rogers Rd Irving, Texas 75060

WELCOME TO OUR OFFICE **Date:** _____

Thanks for choosing our office. To be able serve you better we need the following information. (Please print) This information is strictly confidential.

Patient Name:_____
First **Last** **Initial**

Social security: _____ Sex: Male Female Date Of Birth: _____

Responsible Party Information:

Name:_____
First **Last** **Initial**

Address:_____

City_____ State_____ Zip Code: _____

Home Phone Number:_____ Cell:_____ Work Phone:_____

Driver's License Number:_____ Email: _____

Employer:_____Occupation:_____ Number of years employed: _____

Date Of Birth: _____ Relationship To The Patient:_____

Reason for today's visit?_____

Whom may we thank for referring you to our office? _____

Is the patient apprehensive to dental treatment? YES NO
Are any teeth sensitive to hot or cold? YES NO
Do your gums bleed or feel irritated? YES NO
Is the patient seeing a physician? YES NO
If, so what is the patient being treated for? _____
Name and Address of the physician:_____
What medications is the patient currently taking? _____
Female, Are you pregnant? YES NO How many months? _____

Please circle any of the following which you had or have at the present time:

-Heart Disease	-Heart Pacemaker	-Ulcers	-Arthritis	-High Blood Pressure
-Diabetes	-Tuberculosis	-Sickle Cell Disease	-Rheumatic Fever	-Anemia
-Hay Fever	-Pain in Jaw	-Heart Murmur	-Kidney Problems	-Nervousness
-HIV+	-Venereal Disease	-Epilepsy or Seizure	-Thyroid Disease	-Hepatitis

Other:_____

Circle any of the following medication you are allergic to:

-Local Anesthetic	-Sulfa Drugs
-Codeine	Penicillin
-Aspirin	-Other: _____

To the best of my knowledge, all of the following answers are correct. I will notify office if there are any changes to my health or changes in medication consumption at next appointment.

Signature: _____