

CORNERSTONE DENTAL CARE
K. John Liddiard, D.M.D.

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Last

First

MI

Male Female

Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell/Pager): _____

Address: _____

City

State

Zip Code

Employer: _____

E-Mail Address: (confidential) _____

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- | | | | |
|-----------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | List all medications: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

* If yes, have you ever been asked by your Physician to pre-medicate with a prophylaxis before coming to an appointment? Yes No

■ Are you now under the care of a physician? Yes No

If yes, please explain: _____

■ Name of Physician: _____ Phone: _____

■ Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

■ Have you ever had any complications with dental treatment? Yes No

If yes, please explain: _____

■ Date of last dental visit? _____ Reason for this visit: _____

■ How often do you brush? _____ Floss? _____ Do your gums bleed? Yes No

■ Are you happy with your smile? _____

REFERRAL INFORMATION

Who may we thank for referring you to our practice? _____

EMERGENCY CONTACT

Emergency contact **NOT** living with you? _____ Relationship: _____ Phone: _____

