Welcome to Bridget Doyle, D.D.S ~ About Your Smile

Patient Information (Please Print)

Patient Name: _____ **M / F**

First Middle Initial Last Date

Likes to be called: _____ DOB: _____ Age: _____ Weight: _____

Patient Health History (Please Answer All Questions)

Do you have or have had any of the following:

Heart Trouble	Yes ☐	No ☐	Anemia	Yes ___	No ___	Ulcers	Yes ___	No ___
Tuberculosis	Yes ☐	No ☐	Pregnant Due Date: _____	Yes ___	No ___	Diabetes	Yes ___	No ___
Hepatitis	Yes ___	No ___	Bleeding	Yes ___	No ___	Epilepsy	Yes ___	No ___
HIV/AIDS	Yes ___	No ___	Med Allergies (List Below)	Yes ___	No ___	Handicapped	Yes ___	No ___
Asthma/ Breathing Problems	Yes ___	No ___	Use of Diet Pills/Diet Aids	Yes ___	No ___	Prosthetic Joints, Plates or Pins	Yes ___	No ___
Alcohol/Drug Abuse	Yes ___	No ___	Rheumatic Feve	Yes ___	No ___	Heart Murmur	Yes ___	No ___
Sickle Cell Anemia	Yes ___	No ___	ADD/ADHD	Yes ___	No ___	Tobacco	Yes ___	No ___

HI Blood Pressure Yes _____ No _____ Low Blood Pressure Yes_____ No _____

Any other Health Problems Not Listed: Yes _____ No _____

If you answered "Yes" to any of the above, please explain: _____

Is the patient taking any medications at this time (including over-the-counter medication ie: aspirin)?

Yes _____ No ____ If "Yes", what type: _____

Is the patient allergic to any medications? Yes____ No ____ If "Yes", what kind: _____

Is the patient allergic to any other material commonly used in a dental office (I.e. latex gloves, anesthesia, etc)?

Yes ____ No ____ If "Yes", what: _____

Does the patient have any dental problems/concerns at this time? Please explain: _____

Parent/Guardian Information – If patient is a minor (Please Print)

Mother/Guardian Name

Father/Guardian Name

Address City Zip Code

( ) Home Phone #

( ) Cell Phone #

Nearest Relative **not** Living with Patient

Relationship to Patient

( ) Phone #

Please list other siblings seen here: _____

Please list how your heard about us : _____

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I understand it is my responsibility to fill out the form correctly and completely. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Parent/Guardian Signature

Date

Dentist Signature

Date