NEW PATIENT FORM

Patient's Name:_____Date of Birth: (D/M/Y)_____Sex: M__F__

Mailing Address: Street: _____

City: _____ Postal Code: _____

Phone:(H)_____(W)_____(C)_____

Emergency contact:_____

Phone (H)_____(W)_____(C)_____

Complete if patient is under 18 years old:

Guardian's name:_____

Relationship to child_____Do you have legal custody of the child yes___no___

MEDICAL HISTORY

Is the patient in excellent health? Yes___No___ If no, give reason:_____

Is the patient under the care of a physician? Yes___No___If yes give reason_____

Name of physician:_____

Female patients: Are you or could you be pregnant? Yes No If yes, what trimester are you in? _____

Is the patient taking any medications? Yes____ No____

If yes, please list and state why:_____

Does the patient have any allergies (Medication/Food/Environmental) Yes____ No____

If yes please list:_____

Has the patient ever had surgery or been hospitalized? Yes____ No___

If yes please explain:_____

Are antibiotics required prior to dental treatment? Yes____ No____ Does patient smoke/how long?_____

Does the patient have or ever been diagnosed with any of the following conditions (please circle):

AIDS/HIV	ADD/ADHD	Allergies
Anemia	Anxiety	Asthma
Autism	Bleeding Disorder	Cancer
Cerebral Palsy	Developmental Delays	Diabetes
Epilepsy	Eye Problems	Hearing Loss
Heart Disease/Defect	Hepatitis	Kidney Disease
Liver Disease	Mental Health Issues	Rheumatic/Scarlet Fever
Seizures	Sickle Cell Anemia	Speech Problems
Tuberculosis	Other:_____	

Is there anything else we should know about the patient's health or medical conditions? Yes___No___

If yes explain:_____

Do you have dental insurance? Yes No If yes, please give your information to the front desk.

I certify that I have read and understand the above questions. If I had questions about this form, they were answered to my satisfaction. I will not hold Dr. Rene Buttar, or any member of his staff responsible for any errors or omissions that I may have made in completing this form.

Patient/Guardian (print name): _____ Date: _____

Signature: _____

Witness (print name): _____ Date: _____

Signature: _____

Dentist's comments: _____

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