FIRST LIGHT | DENTAL OF COASTAL VIRGINIA

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ___

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

The best time to contact me is: □ Morning □ Mid-Day □ Evening on □ Home phone □ Cell phone □ Work phone

Email Address_____

Address: _____City:_____ State: _____ Zip: _____

Date of Birth (M/D/Y): ____ /____ /_____ Gender: □M □ F Social Security Number (SSN): _____

Marital Status: □ Married □ Single □ Life Partner □ Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____

Phone_____

Employer Information

Employer: _____ Phone: (____) _____Fax: (____)_____

Address: _____City_____ State: _____Zip: _____

Responsible Party Information

Name _____ DOB (M/D/Y): ____ /____ /_____

Relationship to patient _____ Phone (_____)_____ Soc. Sec. # _____

Address_____ City_____ State: _____ Zip _____

Employer: _____Occupation: _____ Work Phone: (_____)_____

Medical Contact

PRIMARY CARE DOCTOR: _____ Phone: _____

If female, please answer the following:

Are you taking birth control pill? Yes No

Are you pregnant? Yes No If yes, # of weeks: _____

Are you nursing? Yes No

Do you smoke or use tobacco? Yes No

I certify this information is true, accurate, and complete to the best of my knowledge. INITIAL: _____ DATE:_____

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Name_____ Today's date_____ Age_____ Birthdate_____

ALLERGIES:

List anything you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION

MEDICATIONS

List all medications you are taking, including prescribed drugs and over the counter drugs, i.e., vitamins and inhalers.

DRUG NAME	DRUG NAME

MEDICAL HISTORY: (please circle yes or no for each)

Alcohol or Drug Abuse	No Yes	Emphysema	No Yes	Hypothyroidism	No Yes
Anemia	No Yes	Epilepsy	No Yes	Hyperthyroidism	No Yes
Angina	No Yes	Fainting Spells/Seizures	No Yes	Kidney disease	No Yes
Anxiety	No Yes	Fibromyalgia	No Yes	Liver Disease	No Yes
Arteriosclerosis	No Yes	Gastrointestinal Disease	No Yes	Memory Loss	No Yes
Arthritis	No Yes	GERD	No Yes	Mental Health Disorder	No Yes
Asthma	No Yes	Gout	No Yes	Mitral Valve Prolapse	No Yes
AFIB	No Yes	Heart attack	No Yes	Neurological Disorder	No Yes
Autoimmune Disease	No Yes	Heart disease	No Yes	Osteoporosis	No Yes
Blood clots/DVT	No Yes	Heart murmur	No Yes	Pace Maker	No Yes
Cancer	No Yes	Heart palpitations	No Yes	Parkinson's Disease	No Yes
Cardiovascular Disease	No Yes	Heart valve disease	No Yes	Pulmonary Embolism	No Yes
Chemo/Radiation	No Yes	Heartburn	No Yes	Sexually Transmitted Disease	No Yes
Congenital Heart Disorder	No Yes	Hemophilia	No Yes	Sinusitis	No Yes
Depression	No Yes	Hepatitis	No Yes	Sleep Apnea	No Yes
Diabetes	No Yes	HIV or AIDS	No Yes	Stroke	No Yes
Dizziness	No Yes	Hypertension	No Yes	Tuberculosis	No Yes
Eating Disorder	No Yes	Hypotension	No Yes	Ulcers	No Yes

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Name_____ Today's date_____ Age_____ Birthdate_____

SURGICAL HISTORY:

SURGERY:	DATE:

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