

**Warren Family Dental**  
Sari Netsky, D.M.D., M.S.

<b>Patient Information</b>			
Patient Name _____		Date _____	
Last	First	MI	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Social Security #: _____		Birth Date: _____	
Phone (Home): _____		(Work): _____ Ext. _____ Best time to call: _____	
Preferred appointment times: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Any Time <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S			
Address: _____			
Street			Apartment #
City	State	Zip Code	

<b>Health Information</b>
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Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**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"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injury         | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | Other: _____                                |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           |   |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• 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: \_\_\_\_\_

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date \_\_\_\_\_

Signature of patient, parent or guardian \_\_\_\_\_

<b>Referral Information</b>		
Whom may we thank for referring you to our practice? <input type="checkbox"/> Another patient, friend <input type="checkbox"/> Another patient, relative		
<input type="checkbox"/> Dental Office	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Newspaper <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Other _____
Name of the person or office referring you to our practice: _____		

<b>Employment Information</b>			
The following is for: <input type="checkbox"/> the patient <input type="checkbox"/> the person responsible for payment			
Employer Name: _____		Occupation: _____	
Address: _____			
Street	City	State	Zip Code