



Providing Accessible Professional Oral Health Care  
For Patients With Special Needs.

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_

Patient's Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Care Facility \_\_\_\_\_

Facility Contact Name \_\_\_\_\_ Title \_\_\_\_\_

Facility Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Name of Physician \_\_\_\_\_

Physician's Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Physician's Phone \_\_\_\_\_ Physician's Fax \_\_\_\_\_

Name of Dentist \_\_\_\_\_

Dentist's Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Dentist's Phone \_\_\_\_\_ Dentist's Fax \_\_\_\_\_

**Please circle all that apply.**

Heart Trouble/Disease	Yes No	Leukemia	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Heart Murmur*	Yes No	Recent Blood Transfusion	Yes No	Recent Weight Loss	Yes No	AIDS	Yes No
Irregular Heart Beat	Yes No	Swelling of Limbs	Yes No	Frequent Diarrhea	Yes No	HIV Positive	Yes No
Angina/Chest Pain	Yes No	Scarlet Fever	Yes No	Diabetes	Yes No	Genital Herpes	Yes No
Heart Attack/Failure	Yes No	Rheumatic Fever*	Yes No	Excessive Thirst	Yes No	Drug Addiction/Alcoholism	Yes No
Congenital Heart Disorder	Yes No	Lung Disease	Yes No	Hypoglycemia	Yes No	Cold Sores	Yes No
Mitral Valve Prolapse*	Yes No	Breathing Problem	Yes No	Liver Disease	Yes No	Fever Blisters	Yes No
Artificial Heart Valve*	Yes No	Shortness of Breath	Yes No	Hepatitis A (Infectious)	Yes No	Herpes	Yes No
Heart Pace Maker*	Yes No	Frequent Cough	Yes No	Hepatitis B or C	Yes No	Convulsions	Yes No
Heart Surgery	Yes No	Hay Fever	Yes No	Night Sweats	Yes No	Epilepsy or Seizures	Yes No
High Blood Pressure	Yes No	Sinus Trouble	Yes No	Yellow Jaundice	Yes No	Fainting or Dizziness	Yes No
Low Blood Pressure	Yes No	Asthma	Yes No	Kidney Problems	Yes No	Glaucoma	Yes No
Stroke	Yes No	Bloody Sputum	Yes No	Renal Dialysis	Yes No	Nervousness	Yes No
Blood Disease	Yes No	Emphysema	Yes No	Thyroid Disease	Yes No	Psychiatric Care	Yes No
Unexplained Fever	Yes No	Tuberculosis	Yes No	Parathyroid Disease	Yes No	Alzheimer's disease	Yes No
Bruise Easily	Yes No	Cancer	Yes No	Arthritis/Gout	Yes No	Allergies (Medicines)	Yes No
Anemia	Yes No	Tumors or Growths	Yes No	Rheumatism	Yes No	Allergies (Pollen/Dust)	Yes No
Excessive Bleeding	Yes No	X-Ray Treatments (Radiation)	Yes No	Pain in Jaw Joints	Yes No	Hives or Rash	Yes No
Sickle Cell Disease	Yes No	Chemotherapy	Yes No	Cortisone Medicine	Yes No	Premedication Needed?	Yes No
Hemophilia (Bleeding Problem)	Yes No	Stomach/Intestinal Disease	Yes No	Artificial Joint*	Yes No		

Describe current or long-term disability/medical condition: \_\_\_\_\_

Medications \_\_\_\_\_

Patient/Custodial/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_