Hutto Premier Dentistry

Please help us keep our records current by completing this form. Thank you!

General Information:

Last Name ______________________________ First ______________________ M.I. ______

Address ______________________________________ City ______________ Zip _________

Cell Phone ____________________________________

Email Address ____

Birth Date ____________________________ Male Female

Employer ____________________________ Driver's License _________________________

Social Security Number (this is required to file insurance claims)_______________________________

Emergency contact name and number ____

Medical History:

Please circle if you currently have, or have ever had, any of the following conditions:

Heart health: heart attack pacemaker high blood pressure heart surgery valve replacement infective endocarditis

Lung health: asthma emphysema tuberculosis (TB)

Blood health: stroke excessive bleeding leukemia

Endocrine: diabetes thyroid disease

Immune health: HIV/AIDS hepatitis

Skeletal: osteoporosis joint replacement

Other: seizures fainting anxiety cancer chemotherapy radiation therapy

Are you allergic to, or have you ever had an adverse reaction to any of the following?

amoxicillin penicillin local anesthetics latex other: _______________________________

Please list additional health problems: ____

Please list the medications you are taking: ____

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____

Please list any surgeries: ____

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Height ________ Weight _________ Females: Are you pregnant or nursing? ____________

I have completed this form to the best of my knowledge. I give permission for Hutto Premier Dentistry to take any necessary diagnostic X-rays, photos, or study models required to enable complete diagnosis and treatment. ***I understand that I will not receive today of therapy if I refuse to take any x-ray that my dentist deems necessary in delivering my care.***

Signature: ____ Date: ____________________