BONITA BEACH DENTAL

Dr. Grady Scott D.M.D.

Today's Date: _____

PATIENT INFORMATION (CONFIDENTIAL)

Name: _____ **Birth Date:** _____

Age: _____ **Gender:** _____ **Height:** _____ **Weight:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Email address:** _____

RESPONSIBLE PARTY (If different from above)

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ **Birth Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Email address:** _____

MEDICAL HISTORY

Have you ever had any of the following? (Circle Y for Yes, N for No)

Y	N	Allergies to any drugs	Y	N	Diabetes/Thyroid problems
Y	N	Take any medications	Y	N	Ulcers/Acid reflux (GERD)
Y	N	Any hospital stays	Y	N	Hepatitis / Liver problems
Y	N	Any operations	Y	N	Seizures / Epilepsy
Y	N	Heart defects	Y	N	Kidney problems
Y	N	Rheumatic/Scarlet Fever	Y	N	Bleeding problems
Y	N	Heart murmur	Y	N	Developmentally delayed
Y	N	High blood pressure	Y	N	Handicaps / Disabilities
Y	N	Chest pain	Y	N	Cerebral palsy
Y	N	Heart arrhythmias	Y	N	Autism
Y	N	Shortness of breath	Y	N	Cancer
Y	N	Asthma / Lung problems	Y	N	Osteoporosis/Osteopenia
Y	N	Pneumonia	Y	N	Use tobacco products
Y	N	Snoring/Sleep apnea	Y	N	Use alcohol

Please discuss any medical problems: _____

Are you currently under the care of a physician: _____ **Date of Last Visit:** _____

Physician: _____ **Phone Number:** _____

If female, is there any chance that you could be pregnant: _____

Please list all medications you are currently taking: _____

_____

Please list all allergies, including medications: _____

The information on this questionnaire is accurate to the best of my knowledge.

Signature of Patient/Legal Guardian **Date**