Dental Specialists of Saginaw
713 W. Bailey Boswell Rd. Suite 100 Saginaw, TX 76179
(817) 847-4040

Patient Information

Patient Name:_____ Preferred Name _____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Other:_____
Social Security #:_____ Birth Date:_____

Phone (Home):_____ Work:_____ Ext:_____ Cell:_____

Email Address:_____

Address:_____
Street Apt:#

_____
City State Zip Code

Health Information

Date of Last Dental Visit _____ Previous Dentist_____ Reason For Today's Visit_____

Have you ever had any of the following? Please check those that apply:

□ AIDS/HIV
□ Allergies_____
_____
□ Anemia
□ Arthritis
□ Asthma
□ Blood Disease
□ Cancer
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Head Injuries
□ Heart Disease
□ Ulcers
□ Hepatitis A B C
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Nervous Disorders
□ Osteoporosis
□ Pacemaker
□ Radiation Treatment
□ Respiratory Problems
□ Sinus Problems
□ Stomach Problems
□ Tuberculosis
□ Tumors
□ Venereal Disease
□ ***Pregnancy***
Due Date:_____
□ ***Rheumatic Fever***
□ ***Artificial Joints***
□ ***Heart Murmur***
□ ***Mitral Valve Prolapse***
□ ***Codeine Allergy***
□ ***Penicillin Allergy***
□ ***Sulfa Allergy***
□ ***Latex Allergy***

□ ***Current Medications***
_____
_____
_____
_____
_____
_____

□ **Other Conditions**
_____
_____
_____
_____
_____

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

Are you under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Are you currently taking **bisphosphonate's** for osteoporosis, breast cancer, prostate cancer, or multiple Myeloma? _____

If female, are you taking birth control pills? _____ If yes, antibiotic therapy may render your birth control ineffective

To the best of my knowledge, all of the preceding 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