BISHOP FAMILY DENTAL

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely.

UPDATED PATIENT INFORMATION

Last Name_____ First Name _____M.I. ____
Home Address_____
City _____ State _____ Zip _____
Date of Birth_____
Cell Phone _____
Home Phone _____
Patient Employer_____ Work Phone_____
Email Address_____
Contact preference (check all that apply)☐Email☐Text☐Other _____

Dental Insurance Provider_____

UPDATED HEALTH HISTORY

Any allergies?☐Latex,☐Penicillin,☐Metal,☐Local Anesthetic, ☐ Sulfa,☐Codeine
Other (explain) _____
Women-- Are you pregnant? ◯Yes ◯No, Nursing? ◯Yes ◯No, Due Date: _____

Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
◯	◯	AIDS/HIV	◯	◯	Diabetes	◯	◯	Radiation Treatment
◯	◯	Anemia	◯	◯	Dizziness	◯	◯	Respiratory Problems
◯	◯	Arthritis, Rheumatism	◯	◯	Epilepsy	◯	◯	Rheumatic Fever
◯	◯	Artificial Heart Valves	◯	◯	Glaucoma	◯	◯	Shortness of Breath
◯	◯	Artificial Joints	◯	◯	Hay Fever	◯	◯	Sinus Problems
◯	◯	Asthma	◯	◯	Headaches	◯	◯	Stroke
◯	◯	Back Problems	◯	◯	Head Injuries	◯	◯	Thyroid Problems
◯	◯	Bleeding abnormally, with extractions or surgery	◯	◯	Heart Murmur	◯	◯	TMJ Dysfunction
			◯	◯	Heart Disease	◯	◯	Tumors
◯	◯	Blood Disease	◯	◯	Hepatitis Type___	◯	◯	Tuberculosis
◯	◯	Blood Pressure High	◯	◯	Herpes	◯	◯	Ulcer
◯	◯	Blood Pressure Low	◯	◯	Mental Disorder	◯	◯	Venereal Disease
◯	◯	Cancer	◯	◯	Mitral Valve Prolapse			
◯	◯	Chemical Dependency	◯	◯	Nervous Disorder			
◯	◯	Chemotherapy	◯	◯	Pacemaker			

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical conditions or medications can affect dental treatment; I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature_____ Date _____
(Patient, legal guardian or authorized agent of patient)

Submit