HOW DID YOU HEAR ABOUT US?

○ GOOGLE ○ DRIVE BY ○ FACEBOOK ○ WEBSITE
○ EXISTING PT ○ ANOTHER OFFICE ○ INS DIRECTORY
○ SIGN ○ OTHER_____

BLUE CEDAR DENTISTRY
121 N Main Ave
Bolivar MO 65613
417-422-4540

PATIENT INFORMATION FOR CHIILD

DATE_____ **Pt NAME_____** **GUARDIAN'S NAME_____** **ADDRESS_____** **__** **_____**	**Pt's DOB_____ SSN_____-_____-_____** **Guardian's DOB_____ SSN_____-_____-_____** **PHONE_____** **EMAIL _____** ***EMERG CONTACT*** **NAME_____#_____** **RELATION_____**

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions to the best

Are you under a physician's care ○ yes ○ no	**If yes, please explain**
Have you ever been hospitalized or had a major surgery ○ yes ○ no	**If yes, please note**
Have you ever had a serious head or neck injury ○ yes	**If yes, please note**
Are you taking any medications, pills, or drugs ○ yes ○ no	**If yes, please list** **_____** **___** **_____** **___**
Do you have any artificial joints ○ yes ○ no	**If yes, list joint and month/year of replacement**
Are you or have you taken a osteoporosis medication ○ yes ○ no	**If yes, please list**
Are you on a special diet ○ yes	
Do you use tobacco ○ yes	
Do you use a controlled substances ○ yes	

Women Only: Pregnant/Trying ○ yes ○ no Nursing ○ yes ○ no Taking Birth Control ○ yes ○ no

ARE YOU ALLERGIC TO ANY TO THE FOLLOWING: ○ Penicillin ○ Sulfa Drugs ○ Aspirin ○ Codeine ○ Anesthetics ○ Metal

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING

o AID/HIV POSITIVE	o CORTISONE MEDIICINE	o HEMOPHILIA	o RADIATION TREATMENT
o ALZHEIMER'S	o DIABETES	o HEPATITIS A	o RECENT WEIGHT LOSS
o ANAPHYLAXIS	o DRUG ADDICTION	o HEPATITIS B OR C	o RENAL DIALYSIS
o ANEMIA	o EASILY WINDED	o HERPES	o RHEUMATIC FEVER
o ANGINA	o EMPHYSEMA	o HIGH BLOOD PRESSURE	o SCARLET FEVER
o ARTHRITIS/GOUT	o EPILEPSY/SEIZURES	o HIGH CHOLESTEROL	o SHINGLES
o ARTIFICIAL HEART VALVE	o EXCESS BLEEDING	o HIVES/RASH	o SICKLE CELL DISEASE
o ARTIFICIAL JOINT	o EXCESS THIRST	o HYPOGLYCEMIA	o SINUS TROUBLE
o ASTHMA	o FAINTING/DIZZY SPELLS	o IRREGULAR HEARTBEAT	o SPINA BIFIDA
o BLOOD DISEASE	o FREQUENT COUGH	o KIDNEY ISSUES	o STOMACH/INTESTINE DISEASE
o BLOOD TRANSFUSION	o FREQUENT DIARRHEA	o LEUKEMIA	o STROKE
o BREATHING PROBLEM	o FREQUENT HEADACHES	o LIVER DISEASE	o SWELLING OF LIMBS
o BRUISE EASILY	o GENITAL HERPES	o LOW BLOOD PRESSURE	o THYROID DISEASE
o CANCER	o GLAUCOMA	o LUNG DISEASE	o TONSILITIS
o CHEMOTHERAPY	o HAY FEVER	o MITRAL VALVE PROLAPSE	o TUBERCULOSIS
o CHEST PAINS	o HEART ATTACK/FAILURE	o OSTEOPOROSIS	o TUMORS OR GROWTH
o COLD SORES/ FEVER BLISTERS	o HEART MURMUR	o PAIN IN JAW	o ULCERS
o CONGENITAL HEAR DISORDER	o HEART PACEMAKER	o PARATHYROID DISEASE	o VENEREAL DISEASE
o CONVULSIONS	o HEART DISEASE	o PSYCHIATRIC CARE	o YELLOW JAUNDICE
ANY OTHER SERIOUS ILLNESS NOT LISTED:			

PATIENT/LEGAL GUARDIAN_____ DATE_____