

Welcome to Downtown Dental

Lanette C. Sikes, D.D.S.

Patient Information

Patient Name: _____ Today's Date _____
Preferred Name _____ Driver's License # _____
Social Security#: _____ Date of Birth: _____
Phone (Home):() _____ Work:() _____ Ext: Cell: _____
Best Time to Call: _____ Preferred appointment time: _____
Address: _____
Email Address _____

Person Responsible for Account

Name: _____ Driver's License# _____
Social Security# _____ Date of Birth: _____
Employer: _____ Insurance Company: _____

Health Information

Date of Last Dental Visit _____ Reason for Today's Visit _____

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

AIDS	Injuries Blood Disease	Hear Murmur	Respiratory Problems
Allergies:	Blood Transfusion	Hepatitis	Rheumatic Fever
Latex	Cancer	High Blood Pressure	Sinus Problems
Penicillin	Diabetes	Jaundice	Stomach Problems
Erythromycin	Dizziness	Kidney Disease	Tuberculosis
Tetracycline	Drug/Alcohol Abuse	Liver Disease	Tumors
Sulfa	Epilepsy	Mental Disorders	Ulcers
Other:	Excessive Bleeding	Mitral Valve Prolapse	Venereal Disease
Anemia	Fainting	Nervous Disorders	Please list any others:
Arthritis	Glaucoma	Pacemaker	_____
Artificial Joints	Hay Fever	Pregnant	_____
Asthma	Head Injuries	Radiation Treatment	_____

Have you ever had any complications following dental treatment? _____

Have you been admitted to a hospital or needed emergency care during the past two years? _____

Are you under the care of a physician? _____

Name of your physician: _____

Do you have any health problems that need further clarification? _____

Are you taking any medications? _____ If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Patient or Guardian Signature: _____ Date: _____

Do we see any other members of your family? _____ if so, please list: _____

Referral Information

Whom may we thank for referring you to our practice? _____