

# Dover Dental Group



Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_

Current Address \_\_\_\_\_

Number

Street

Apt. #

City

State

Zip Code

Current Phone Number:

Home \_\_\_\_\_

Cell \_\_\_\_\_

Work \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

1) Has there been a change in your health since your last visit? Yes  No

If yes, Please explain: \_\_\_\_\_

2) Are you taking any new medications? Yes  No

If yes, please list: \_\_\_\_\_

3) Do you have any new allergies? Yes  No

If yes, please list: \_\_\_\_\_

**Women:** Are you pregnant? Yes  No

If yes, how many months? \_\_\_\_\_

Nursing? Yes  No

The information provided is accurate to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian if minor)

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_