The 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 _____

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Telephone #: (614) 939-8338 Fax #: (614) 939-8340