MARK GIVAN DDS

Chart # _____
FOR OFFICE USE ONLY

## PATIENT INFORMATION

Patient Name: _____ Date _____

Phone (Home) _____ (Work) _____ (Cell) _____

Address: _____
(house number, street and apartment number if applicable)

_____
(City, State, Zip)

## HEALTH INFORMATION

Have you ever had any of the following? (please check all that apply)

- ☐ Medication Allergies
  _____
  _____
  _____
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Sensitivity
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Sinus Problems
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Stomach Problems
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ AIDS/HIV

Other
- _____
- _____
  _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No
If yes, please explain: _____

Name of physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

Please list all medications you are currently taking: (such as drugs, pills, and herbal remedies):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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

_____ _____
Signature of patient, parent or guardian Date

_____ _____
Mark S. Givan, D.D.S. Date