



Health Information

BOE FAMILY DENTISTRY
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(952) 475-0989
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Patient Information:
Name: Date of Birth: Male Female
In Case of Emergency: Relationship to you: Emergency Contact Phone:
Name of Physician: Physician Phone:
Clinic or Facility Name: Clinic Phone:
Pharmacy Name: Pharmacy Phone:

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

YES NO YES NO
Arthritis Thyroid Condition
Hip or Joint Replacement Venereal Disease
High Blood Pressure Kidney Disorder
Low Blood Pressure Pacemaker
Radiation or Chemical Therapy Rheumatic Fever
Diabetes Allergies
Hepatitis Fainting Spells
Ulcers Ear Infections
Hemophilia, Bleeding or Blood Disorder Hydrocephalus
Epilepsy or Seizures Chronic Sinus
Enzyme Deficiency (i.e. G6PD) Asthma or Hay Fever
Anemia, Sickle Cell Disease Tuberculosis
Acquired Immune Deficiency (HIV) Chemical Dependency Treatment
Heart Murmur Anorexia/Bulimia
Chronic Diarrhea Blood Transfusion
Pre-medication for Dental Treatment Surgical Operation
Have you ever had an allergic reaction or been told not to take any medication? If yes, describe:
Are you currently taking any prescription drug of any kind? (i.e. birth control, hormone, diet) If yes, what?
Are you currently taking any non-prescription drugs of any kind? (i.e. aspirin, cough syrup, nasal spray, high caffeine, recreational drug use) If yes, what?
Are you pregnant? If yes, what is your anticipated delivery date and are you or will you nurse?
Do you use tobacco? If yes, daily intake:
Do you wear contact lenses?
Do you have any disease, condition or problem not listed that we should know about? If yes, explain:

I CERTIFY THIS MEDICAL INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: Date:

Patient or Guardian of Minor

Please fill out a new health form every three years.