GRANTSVILLE
FAMILY DENTISTRY
HOLLY E. SISLER, D.D.S.

It is very important that we know the following information about you prior to any treatment.

PATIENT INFORMATION

Name: _____ Sex: M or F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone#: _____

Date of Birth: _____ Social Security #: _____

E-Mail Address: _____

EMPLOYER INFORMATION

Employer Name: _____Phone# _____

Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone#: _____

HEALTH QUESTIONS

1. Is your general health good? Yes or No
2. Do you have a Primary Care Physician? Yes or No
   - If Yes, Physician's Name & Phone Number

   _____
3. Are you currently taking any medications? Yes or No If Yes, please list

   _____

   _____
4. Are you currently taking any blood thinners? Yes or No If Yes, please list

   _____
5. Do you currently use Tobacco Products? Yes or No
6. Are you allergic to any medications? Yes or No If Yes, please list

   _____

   _____

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7. Do you have, or ever had any of the following:

- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ Heart murmur/mitral prolapse
- ☐ Jaundice
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Venereal disease
- ☐ HIV +/AIDS
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Prolonged Bleeding
- ☐ Allergies
- ☐ Tumor or other growth
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Chest pain on mild exertion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Ulcer
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Valve Replacement
- ☐ Joint Replacement
  - Body Part(s)_____
  - Date(s)_____
- ☐ Anxiety/Depression
- ☐ Currently Pregnant

8. Any other problems we should be aware of: _____

This information is strictly confidential and will not be released without your permission. The guarantor of this account is responsible for payment in full.

Signature: _____ Date: _____

(Patient, parent or guardian **MUST** sign prior to treatment)

After you review the attached Privacy Policy/HIPAA Compliance please sign below:

Signature: _____Date: _____