

NORDSTROM DENTAL NEW PATIENT INFORMATION

Patient Information

Patient Name: _____ Male Female
Last First MI (Preferred Name)
Date of Birth: _____ Occupation/Employer: _____
Email Address: _____
Phone (Home): _____ (Work): _____ (Cell): _____
Address: _____
Street Apartment #
City Province Postal Code

Health Information

Date of Last Dental Visit: _____ Previous Dentist: _____
Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| Date: _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replaced | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Diabetes | Date: _____ | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |

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

• Have you ever had surgery or been hospitalized for a serious illness? Yes No
If yes, please explain: _____

• Please list any current medications: _____

• Please list any current allergies: _____

• Name of Physician: _____ Phone: _____

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

To the best of my knowledge, all of 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: _____

Referral Information

How did you hear about Nordstrom Dental? Friend or Relative Saw the office and decided to call or come in
 Website Google Yellow Pages MFRC School Work Other _____

Name of person referring you to our practice: _____

May we contact you via email or text message to remind you of future appointments? Yes No