NORDSTROM DENTAL NEW PATIENT INFORMATION

Patient Name:	Patient Information					
Last First MI (Preferred Name) Date of Birth: Occupation/Employer:	Patient Name:				□ Male □ Female	
Email Address:	Last	First	MI	(Preferred Name)		
Phone (Home):	Date of Birth: Occupation/Employer:					
Mailing Address:	Email Address:					
City Province Postal Code Health Information Date of Last Dental Visit: Previous Dentist: Reason for this visit: Previous Dentist: City Previous Dentist: Reason for this visit: Previous Dentist: Do you have or have you ever had any of the following? Please check those that apply: Thyroid Disorder AIDS Glaucoma Mental Disorders Thyroid Disorder Anemia Head Injuries Osteoporosis Tumors Artificial Joints Head Numur Pregnancy Recent travel to areas where endemic disease is present Chemotherapy Heat Valve Replaced Due date: areas where endemic disease is present Dibziness Heipatitis A B C Respiratory Problems OTHER: Please enoreven ha	Phone (Home):	(Work):		(Cell):		
City Province Postal Code Health Information Date of Last Dental Visit: Previous Dentist: Reason for this visit: Previous Dentist: City Previous Dentist: Reason for this visit: Previous Dentist: Do you have or have you ever had any of the following? Please check those that apply: Thyroid Disorder AIDS Glaucoma Mental Disorders Thyroid Disorder Anemia Head Injuries Osteoporosis Tumors Artificial Joints Head Numur Pregnancy Recent travel to areas where endemic disease is present Chemotherapy Heat Valve Replaced Due date: areas where endemic disease is present Dibziness Heipatitis A B C Respiratory Problems OTHER: Please enoreven ha	Mailing Address:			Ar	partment #	
Health Information Date of Last Dential Visit:						
Date of Last Dential Visit: Previous Dentist: Reason for this visit: Previous Dentist: Do you have or have you ever had any of the following? Please check those that apply: Stroke/TIA AIDS Fainting Liver Disease Stroke/TIA Anemia Hay Fever Mental Disorders Inturoris Anemia Hay Fever Mental Disorders Inturoris Antificial Joints Head Injuries Osteoporosis Inumors Asthma Heart Narwer Pregnancy Recent Travel to Cancer Heart Stents Radiation Treatment Giesaes is present Dizziness High Blood Pressure Recomit Fever ONE Dizziness High Blood Pressure Stomach Problems OTHER: Pizeessive Bleeding Kidney Disease Stomach Problems OTHER: • Have you ever had any complications following dental treatment? Yes No • Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? Yes No • Have you ever had surgery or been hospitalized for a serious illness? Yes No If yes, please explain:	City					
Reason for this visit:	Health Information					
□ AIDS □ Fainting □ Liver Disease □ Stroke/TIA □ Acid Reflux (GERD) □ Glaucoma □ Mental Disorders □ Tuberculosis □ Antificial Joints □ Head Injuries □ Ostoporosis □ Tumors □ Artificial Joints □ Heart Disease □ Pacemaker □ Ulcers □ Astima □ Heart Valve Replaced □ uc date: areas where endemic □ Cancer □ Heart Stents □ Radiation Treatment disease is present □ Dizziness □ Heigh Blood Pressure □ Recent travel to □ Dizziness □ High Blood Pressure □ Recent travel on infectious disease? □ Yes □ No ○ Doyou have a family history of prion disease (Creutzfeld-Jakob) or sudden onset dementia? □ 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: • Please list any current medications: □ Date:						
Acid Reflux (GERD) Glaucoma Mental Disorders Thyroid Disorder Anthritis Head Injuries Osteoporosis Tumoros Anthritis Head Injuries Osteoporosis Tumoros Asthma Heart Disease Pacemaker Ulcers Asthma Heart Murnur Pregnancy Recent travel to Chemotherapy Heart Stents Radiation Treatment disease is present Dizziness High Blood Pressure Rheumatic Fever ortherapy Excessive Bleeding Kidney Disease Stomach Problems Have you ever had any complications following dental treatment? Yes No If yes, please explain:	Do you have or have you eve		wing? P			
□ Anemia □ Hay Fever □ Nervous Disorders □ Tuberculosis □ Anthritis □ Heart Disease □ Pacemaker □ Ulcers □ Astificial Joints □ Heart Murmur □ Pregnancy □ Recent travel to □ Cancer □ Heart Valve Replaced □ Due date: □ areas where endemic □ Cancer □ Heart Stents □ Radiation Treatment □ isease is present □ Dizziness □ High Blood Pressure □ Recurnatic Fever □ Dizziness □ High Blood Pressure □ Stimus Problems □ Have you recently developed a cough, fever, chills, diarrhea, rash, or had exposure to infectious disease? □ Yes □ No □ Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain:		0				
□ Arthritis □ Heart Injuries □ Osteoporosis □ Tumors □ Arthritis □ Heart Disease □ Pregnancy □ Recent travel to □ Cancer □ Heart Valve Replaced □ Due date:						
Asthma Heart Murmur Pregnancy Recent travel to areas where endemic Chemotherapy Heart Stents Radiation Treatment disease is present Diabetes Hepatitis A B C Respiratory Problems OTHER: Dizziness High Blood Pressure Rheumatic Fever OTHER: Epilepsy Jaundice Stomach Problems OTHER: • Have you recently developed a cough, fever, chills, diarrhea, rash, or had exposure to infectious disease? Yes No • Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? Yes No • Have you ever had any complications following dental treatment? Yes No If yes, please explain:		5				
Cancer Heart Valve Replaced Due date:	Artificial Joints			Pacemaker		
□ Chemotherapy □ Heart Stents □ Radiation Treatment disease is present □ Dizziness □ High Blood Pressure □ Respiratory Problems OTHER:						
□ Diabetes □ Hepatitis A B C □ Respiratory Problems OTHER:						
□ Dizziness □ High Blood Pressure □ Rheumatic Fever □ Epilepsy □ Jaundice □ Sinus Problems □ Excessive Bleeding □ Kidney Disease □ Stomach Problems • Have you recently developed a cough, fever, chills, diarrhea, rash, or had exposure to infectious disease? □ Yes □ No • No • Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? □ Yes □ No • No • Have you ever had any complications following dental treatment? □ Yes □ No If yes, please explain:						
Epilepsy Jaundice Sinus Problems Excessive Bleeding Isinus Problems Stomach Problems Have you recently developed a cough, fever, chills, diarrhea, rash, or had exposure to infectious disease? Yes No Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? Yes No Have you ever had any complications following dental treatment? Yes No Have you ever had surgery or been hospitalized for a serious illness? Yes No If yes, please explain:			Iro		OTHER	
Excessive Bleeding Kidney Disease Stomach Problems • Have you recently developed a cough, fever, chills, diarrhea, rash, or had exposure to infectious disease? Yes No • Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? Yes No • 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: Clinic: Clinic: 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. Signature of patient, parent or guardian Referral Information How did you hear about Nordstrom Dental? Friend or Relative Saw the office driving by Who may we thank for referring you to our practice:						
• Do you have a family history of prion disease (Creutzfeldt-Jakob) or sudden onset dementia? \rightarrow Yes \rightarrow No • Have you ever had any complications following dental treatment? \rightarrow Yes \rightarrow No If yes, please explain:						
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• Please list any current allergies: • Name of Physician: Clinic: 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 Date: Date: Date: Signature of patient, parent or guardian Referral Information How did you hear about Nordstrom Dental? □ Friend or Relative □ Saw the office driving by □ Website □ Google Search □ Facebook □ Newspaper □ Phone Book □ MFRC □ Other	If we also a supply to					
Name of Physician: Clinic: 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. Date: Date: Signature of patient, parent or guardian Referral Information How did you hear about Nordstrom Dental? □ Friend or Relative □ Saw the office driving by □ Website □ Google Search □ Facebook □ Newspaper □ Phone Book □ MFRC □ Other Who may we thank for referring you to our practice:	Please list any current medications:					
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. Date: Date: Signature of patient, parent or guardian Referral Information How did you hear about Nordstrom Dental? Friend or Relative Saw the office driving by Who may we thank for referring you to our practice:	Please list any current allergies:					
change in my health, I will inform the doctors at the next appointment	Name of Physician: Clinic:					
Signature of patient, parent or guardian Referral Information How did you hear about Nordstrom Dental? Friend or Relative Saw the office driving by Website Google Search Facebook Newspaper Phone Book MFRC Other						
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How did you hear about Nordstrom Dental?	Signature of patient, parent or guardian					
□ Google Search □ Facebook □ Newspaper □ Phone Book □ MFRC □ Other	Referral Information					
Who may we thank for referring you to our practice:	How did you hear about Nordstrom Dental? \Box Friend or Relative \Box Saw the office driving by \Box Website					
Who may we thank for referring you to our practice:	□ Google Search □ Facebook □ Newspaper □ Phone Book □ MFRC □ Other					
	Who may we thank for referring	g you to our practice:				

May we contact you via email or text message to remind you of future appointments?