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): ______________

Mailing Address: ____
Street Apartment #

____
City Province Postal Code

Health Information

Date of Last Dental Visit: ______________ Previous Dentist: ______________________
Reason for this visit: ____

Do you have or have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Acid Reflux (GERD)
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Heart Valve Replaced
☐ Heart Stents
☐ Hepatitis A B C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke/TIA
☐ Thyroid Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Recent travel to areas where endemic disease is present
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: ____
- 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: ______________

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: ______________
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:

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