Dental Procedure Medical Information Form

Patient Information

Full Name

Date of Birth

Phone Number

Email

Address

Emergency Contact

Name

Phone Number

Relationship

Medical History

Primary Physician

Physician Phone

Current Medications

Known Allergies

Medical Conditions (e.g., diabetes, heart disease, etc.)

Past Surgeries or Hospitalizations

Dental Information

Dental Procedure

Dental Concerns (pain, sensitivity, bleeding, etc.)

Date of Last Dental Visit

Additional Information

Additional Notes / Concerns