Earl L. Estwick, D.M.D., P.C. • Bard Professional Bldg.
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Patient Information

Patient Name: _____ Date: _____
Last First MI

Gender: _____ Family Status: _____ Social Security #: _____ Birth Date: _____

Phone (Home): _____ Cell: _____ Work Phone: _____ Email: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment City State Zip Code

Health Information

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

☐ AIDS	☐ Cough, Persistent	☐ Heart Problems	☐ Pacemaker	☐ Tuberculosis
☐ Artificial Heart Valves	☐ Diabetes	☐ Hemophilia	☐ Penicillin Allergy	☐ Tobacco
☐ Anemia	☐ Dizziness	☐ Hepatitis	☐ Pregnancy, Due date_____	☐ Tonsillitis
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tumors
☐ Artificial Joints	☐ Excessive Bleeding	☐ HIV	☐ Respiratory Problems	☐ Ulcers
☐ Asthma	☐ Fainting	☐ Jaundice	☐ Rheumatic Fever	☐ Venereal Disease
☐ Blood Disease	☐ Glaucoma	☐ Jaw Pain	☐ Rheumatism	☐ OTHER:
☐ Cancer	☐ Growths	☐ Kidney Disease	☐ Scarlet Fever	
☐ Chemical Dependency	☐ Hay Fever	☐ Leukemia	☐ Sinus Problems	_____
☐ Circulatory Problems	☐ Head Injuries	☐ Liver Disease	☐ Stomach Problems	
☐ Codeine Allergy	☐ Headaches	☐ Mental Disorders	☐ Stroke	_____
☐ Cortisone Treatments	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Problems	
☐ Coumadin	☐ Heart Murmur	☐ Nervous Disorders		

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking prescribed medications: _____ Please include Birth Control _____

If yes, please list _____

Name of pharmacy: _____ Phone: _____

List any / all allergies: _____

Patient Signature: _____ Date: _____