NORDSTROM DENTAL
RETURNING PATIENT INFORMATION

Patient Information

Patient Name: _____
Last First MI (Preferred Name)

Has your address changed? ☐ Yes ☐ No Has your dental insurance changed? ☐ Yes ☐ No

If yes to either: _____

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

Email address: _____

Please update your medical history for us:

Health Information

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

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Heart Valve Replaced
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ 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: _____ 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.

_____ Date: _____
Signature of patient, parent or guardian