Welcome to
Fletcher Heights Dental Care, P.C.
Dr. Michael A. Prost
8272 W Lake Pleasant Parkway, Suite 204
Peoria, AZ 85382
623-825-7833

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Social Security #: ____________ Birth Date: ______________ Gender: M F Family Status: ___________

Phone (Home): ______________ (Work): ______________ (Cell): ______________

Email: ____________________ Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ____________ Reason for this visit: ______________________

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

☐ AIDS/HIV +	☐ Fainting	☐ Nervous Disorders	☐ Tumors
☐ Allergies ___________	☐ Glaucoma	☐ Pacemaker	☐ Ulcers
☐ Alcohol Abuse	☐ Artificial Heart Valves	☐ Pregnancy	☐ Venereal Disease
☐ Anemia	☐ Hay Fever	Due date:_________	☐ Codeine Allergy
☐ Arthritis	☐ Head Injuries	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Artificial Joints/Bones	☐ Heart Disease	☐ Respiratory Problems	☐ Sulfa Allergy
☐ Asthma	☐ Heart Murmur	☐ Rheumatic Fever	☐ Erythromycin Allergy
☐ Blood Transfusions	☐ Hepatitis	☐ Rheumatism	☐ Aspirin Allergy
☐ Cancer	☐ High Blood Pressure	☐ Sinus Problems	☐ Latex Allergy
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	☐ Other: ________________
☐ Dizziness	☐ Kidney Disease	☐ Stroke	
☐ Epilepsy	☐ Liver Disease	☐ Thyroid Disease	
☐ Excessive Bleeding	☐ Mental Disorders	☐ Tuberculosis	

- Do you smoke or use tobacco products? ☐ Yes ☐ No
  If yes, how long: ______________________________
- Are you now taking or have taken prescription medication or over the counter during the past year? ☐ Yes ☐ No
  If yes, please list: ______________________________
- 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: ______________________________

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

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend/ relative ☐ Dental Office ☐ Yellow Pages ☐ Flyer ☐ School ☐ Work ☐ Other ______________________________

Name of person, office, and/or flyer referring you to our practice: ______________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________ Birth Date: ______________ Phone (Home): ______________

(Cell): ______________ Best time to call: __________

Address: ____
Street Apartment # City State Zip