3 Angels Health & Wellness Center
NEW PATIENT INFORMATION FORM

Please print clearly:

Name: _____ Date: _____

Address: _____ Apt. #: _____

City:_____ State: _____ ZIP: _____

Shipping Address:_____

_____

Home Phone: (____) ____-_____ Work Phone: (____) ____-_____

E-mail address: _____

REFERRED BY:_____

Occupation: _____ Employer: _____

Date of Birth:_____ Age: _____ Sex: M/F Height:_____ Weight:_____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Current health complaints: _____

_____

Previous treatments for these complaints: _____

_____

Have you had any dental procedures or dental surgery? (braces, metal filings, extractions, root canal, crowns, implants, ext.): _____

_____

Do you need further or future dental work? If so what and when? _____

_____

Current medications/recreational drugs being taken: _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking:_____

_____

Do you smoke, drink coffee or alcohol? (If yes indicate how much)

Cigarettes: _____ Coffee:_____ Alcohol: _____

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Office Use Only:

3 Angels Health & Wellness Center
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Name: _____ Date: _____

HISTORY:

List any major illnesses or diagnoses received with approx. dates: _____

_____

List any surgery or operations with approx. date:_____

_____

List any skin scares: (acne scars, skin abrasions, piercings etc.):_____

_____

Past accidents or injuries: _____

_____

Do you have any allergies (food or environmental)? _____

Have you had vaccinations recently or regularly? _____

_____

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Marital Status: S M D W Name of Spouse:_____

Describe health of spouse: _____ Number of children if any : ___

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other: _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?_____

_____

For Women: Are you using a prescribed method of birth control? Y / N

Are you pregnant? Y / N Week #:_____

Are you nursing? Y / N

SIGNED:_____ DATE:_____