PATIENT INFORMATION

Welcome to our office! *To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

Patient's name ______________________ Preferred name ______________ Birth Date________

Primary Phone #__________ Home Ph #__________ If minor, parents names ______________________

Mailing address____________________________ City______________ State____ Zip_______

Email address ______________________________

Employer ______________________________

Spouse's name ______________________ Spouse's employer ________________ ❑ Unmarried

Whom may we thank for referring you to our office? ______________________ ❑ Online

Emergency contact______________________________ Phone #______________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ **Not covered by dental insurance**

Your Social Security number: __________ Dental Insurance Co.______________ Enrollee ID # ________

Covered by additional insurance? ❑ yes ❑ no

Secondary Dental Insurance Co. ______________________ Enrollee ID # ______________

Subscriber's name________________ Birth Date__________ Social Security number ________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

- ❑ Cancer or tumor? if so, what type?
- ❑ Radiation treatment
- ❑ Thyroid problems
- ❑ Heart ailment or angina
- ❑ Heart attack or stroke? if so, whem?
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve? If so, when?
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Emphysema
- ❑ Ulcers
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Hospitalized for any reason

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Bone density medicine - bisphosphonates

Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

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Name of your physician:______________________________

Signature of patient (or parent) ______________________________ Date____________

Signature of dentist ______________________________ Date ____________