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__________

If minor, guardian's name ______________________ Preferred number ______________(Cell / Home/ Work)

Mailing address ______________________ Apt #_____City ___________ State ________ Zip __________

Email address ______________________Relationship status______________________

Employer ______________________ Occupation ______________________

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

Emergency Contact's Name ______________________ Phone Number______________________

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

Dental Insurance Co.______________ Group number______________ Your Social Security number: ______________

Covered by spouse's insurance? ❑ Yes ❑ No

Spouse's name ______________________ Spouse's employer ______________________

Spouse's dental insurance company ______________________ Group number ______________________

Spouse's date of birth ______________________ Social Security number ______________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Artificial joint or valve, when?__________________
- ❑ Asthma
- ❑ Cancer or tumor
- ❑ Diabetes (Type I or II)
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Hayfever or sinus trouble
- ❑ Heart attack, when?__________________
- ❑ Heart condition, specify__________________
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease or problems
- ❑ Migraine headaches or frequent headaches
- ❑ Pacemaker
- ❑ Stroke, when?__________________
- ❑ Tuberculosis or other lung problems

Women:

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

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

- ❑ Codeine or other narcotics
- ❑ Latex materials
- ❑ Local anesthetics ("Novocain")
- ❑ Penicillin or other antibiotics
- ❑ Sulfa drugs
- ❑ Other:______________________

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you ever taken antibiotics for dental treatment?

❑ yes ❑ no why?______________________

Please list the **current** medications that you are taking:

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Name of your physician: ______________________

Do you have any disease, condition, or problem not listed above?______________________

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Please add anything else you would like us to know about: ______________________

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Signature of patient (or guardian)______________________ Date ______________