

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 _____ Birthdate _____

If minor, parents names _____ Home phone _____ Cellphone _____

Mailing address _____ City _____ State _____ Zip code _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's employer _____ Unmarried

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

Your Social Security number _____ Dental Insurance Co. _____ ID number _____

Group number _____ Covered by spouse's Insurance co.? Yes No Spouse's birthdate _____

MEDICAL HEALTH HISTORY

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

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDs or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, trauma
- Hayfever or sinus trouble
- Asthma

Do you smoke or use chewing tobacco? Yes No

Name of your primary care physician _____

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

Please add anything else you would like us to know about _____

Signature of patient (or parent, if minor) _____ Date _____

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?

- 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
- Osteoporosis (bone density) medicine
- Other _____

Women:

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