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__________

Home phone ________________ Cell phone ________________Work Phone______________

**Email Address____

Mailing address ______________________ City ____________State ______ Zip _______

(circle one) Single Married Divorced Widowed Whom may we thank for referring you ? ________________

RESPONSIBLE PARTY/ SUBSCRIBER:______________________ ❑ Not covered by dental insurance

Social Security number: ________________ DOB__________

Primary Insurance Company________________ID#____________Group#__________

Secondary Insurance Company ______________ ID#____________Group# __________

Secondary Subscriber ______________ Social Security number ____________DOB______

MEDICAL HEALTH HISTORY

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

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Allergies or hives to:______________
- ❑ Alzheimer's or Dementia
- ❑ Anemia or blood disorders
- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial joint or valve
- ❑ Asthma
- ❑ Bulimia Nervosa
- ❑ Blood transfusion
- ❑ By-Pass Surgery
- ❑ Cancer or tumor CHEMO or RADIATION Treatments?
- ❑ Diabetes
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Hayfever or sinus trouble
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Valve Replacement
- ❑ Hepatitis A B C or other liver disease (please circle)
- ❑ Herpes or cold sores
- ❑ High Blood Pressure
- ❑ Kidney disease
- ❑ Low Blood Pressure
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Osteoporosis or other bone disorders
- ❑ Pacemaker
- ❑ Stroke Date__________

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

- ❑ Tuberculosis or other lung or respiratory problems
- ❑ Thyroid
- ❑ Ulcers

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

- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics______________
- ❑ Latex materials
- ❑ Local anesthetics (list)______________
- ❑ NSAID
- ❑ Penicillin or other antibiotics (list)__________
- ❑ Sulfa drugs
- ❑ Other:______________________

Are you taking any of the following?

- ❑ Antibiotics or sulfa drugs
- ❑ Anticoagulants (blood thinners)
- ❑ Antidepressants or tranquilizers
- ❑ Aspirin
- ❑ Bisphosphonates
- ❑ Cortisone or other steroids
- ❑ High blood pressure medicine
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:______________________

Women:

- ❑ Pregnant or may be Pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Are you under the care of a physician?________Name of your physician:______________________

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

Have you been hospitalized or had serious illness within the past 5 years? Y/N Explain______________

List all medications you are taking by prescription, over the counter or illicit drugs:______________

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Signature of patient (or guardian) ______________________ Date __________