PATIENT INFORMATION

ABOUT YOU

Today's Date: ______/______/______

Patient Name: Last: ______ First: ______ MI ______

☐ Male ☐ Female What You Prefer To Be Called: ______

Birthdate: ____/____/____ Age: ______ SS#: ______

Mailing Address: ______

City: ______ State: ______ Zip: ______

Home Phone #: (______) ______ Work Phone #: (______) ______ Ext: ______

Cell Phone #: (______) ______ E-Mail Address: ______

Referred By: ______

Employer: ______

Occupation: ______

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: ______

INSURANCE INFO

Primary Dental Insurance

Insurance Name: ______

Phone #: (______) ______

Employer: ______

Subscribers Name: ______

Date of Birth: ____/____/____

SS #: ______

ID #: ______

Group #: ______

Patent's Name: ______

Date of Birth: ____/____/____

Relation to Subscriber: ______

Secondary Dental Insurance

Insurance Name: ______

Phone #: (______) ______

Employer: ______

Subscribers Name: ______

Date of Birth: ____/____/____

SS #: ______

ID #: ______

Group #: ______

Patent's Name: ______

Date of Birth: ____/____/____

Relation to Subscriber: ______

ACCOUNT INFO

Person ultimately responsible for account:

Name: ______

Relation: ______

City: ______ State: ______ Zip: ______

SS#: ______ Driver's License # ______

Work Phone #: (______) ______ Ext: ______

IN EVENT OF EMERGENCY

Whom should we contact? ______ Relation: ______

Home Phone #: (______) ______ Work Phone #: (______) ______ Ext: ______

Cell Phone #: (______) ______

Who is your Medical Doctor? ______

Medical Doctor's Phone #: (______) ______

MEDICAL HISTORY

PATIENT NAME ______________________________ **Birth Date** ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________

Are you taking any medications or supplements? If yes, please list ◯ Yes ◯ No ____________

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Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Have you had hip, shoulder, knee, or joint replacement? ◯ Yes ◯ No If yes, what was the date of the procedure? ____________

Do you use tobacco? ◯ Yes ◯ No If yes, type?: ____________ Frequency? ____________

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant / Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: ____________

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯	◯	Congestive Heart Failure	◯	◯	Hemophilia	◯	◯	Radiation Treatments	◯	◯
Alcohol Use	◯	◯	Convolutions	◯	◯	Hepatitis A	◯	◯	Renal Dialysis	◯	◯
Alzheimer's Disease	◯	◯	Coronary Angioplasty	◯	◯	Hepatitis B or C	◯	◯	Rheumatism	◯	◯
Anaphylaxis	◯	◯	Coronary Bipass	◯	◯	Herpes	◯	◯	Shingles	◯	◯
Anemia	◯	◯	Diabetes	◯	◯	High Blood Pressure	◯	◯	Sickle Cell Disease	◯	◯
Aneurysm	◯	◯	Dialysis	◯	◯	High Cholesterol	◯	◯	Sinus Trouble	◯	◯
Angina	◯	◯	Drug Addiction	◯	◯	Hypoglycemia	◯	◯	Spine Bifids	◯	◯
Arrhythmias	◯	◯	Easily Winded	◯	◯	Irregular Heartbeat	◯	◯	Stomach/Intestinal Disease	◯	◯
Arthritis/Gout	◯	◯	Emphysema	◯	◯	Kidney Problems	◯	◯	Stroke	◯	◯
Artificial Heart Valve	◯	◯	Epilepsy or Seizures	◯	◯	Leukemia	◯	◯	Tendency to bleed longer than normal	◯	◯
Asthma	◯	◯	Excessive Bleeding	◯	◯	Liver Disease	◯	◯	Thyroid Disease	◯	◯
Blood Disease	◯	◯	Excessive Thirst	◯	◯	Low Blood Pressure	◯	◯	Tobacco Use	◯	◯
Blood Transfusion	◯	◯	Fainting Spells/Dizziness	◯	◯	Lung Disease	◯	◯	Tonsillitis	◯	◯
Cancer	◯	◯	Frequent Cough	◯	◯	Lupus	◯	◯	Tuberculosis	◯	◯
Chemotherapy	◯	◯	Frequent Headaches	◯	◯	Mitral Valve Prolapse	◯	◯	Tumors or Growths	◯	◯
Chest Pains	◯	◯	Glaucoma	◯	◯	Osteoporosis	◯	◯	Ulcers	◯	◯
Cirrhosis	◯	◯	Heart Attack/Failure	◯	◯	Pain in Jaw Joints	◯	◯	Yellow Jaundice	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯			
Congenital Heart Disorder	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________

Comments: ____________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ____________ **DATE** ____________