PATIENT INFORMATION

Print Form

Date: Patient Name: ☐ Male ☐ Female

Address: City: State: Zip:

Home#: Work#: Cell#:

Email: SS#: Date of Birth: Age:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Employer:

Closest Relative Not Living With You: Phone#:

Emergency Contact: Phone#:

General Dentist Name: Who referred you to our office?

Is a friend or relative a patient in our office? ☐ Yes ☐ No If so, Name and Relationship:

SPOUSE/SIGNIFICANT OTHER

Name: Name of Employer:

SS#: Date of Birth:

Work#: Cell#:

INSURANCE INFORMATION

Primary Insurance: Secondary Insurance:

Policy Holders Name: Policy Holders Name:

Relationship to Patient: Relationship to Patient:

SS# or ID#: SS# or ID#:

Date of Birth: Date of Birth:

Group#: Group#:

Are you having pain or discomfort at this time? ☐ Yes ☐ No

Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Physician's Name: _____ Phone #: _____

Address: _____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

If yes, please list: _____

Are you taking any type of blood thinning medications, such as Coumadin or Aspirin related products? ☐ Yes ☐ No

Please specify: _____

Are you taking Plavix? ☐ Yes ☐ No

Are you taking any type of Bisphosphonates or Bone-Sparing drugs (Aredia, Nometa, Fosamax)? ☐ Yes ☐ No

Please specify: _____

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ☐ Yes ☐ No

If yes, please list: _____

Indicate which of the following you have had or have at the present.

Heart Failure ☐ Yes ☐ No	Artificial Joints(hip,knee,etc.) ☐ Yes ☐ No	Hepatitis B (serum) ☐ Yes ☐ No
Heart Disease or Attack ☐ Yes ☐ No	Kidney Trouble ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Angina Pectoris ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No	A.I.D.S/H.I.V. Positive ☐ Yes ☐ No
Congenital Heart Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Headaches/Migraines ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No	Thyroid Problem ☐ Yes ☐ No	Cold Sores/Fever Blisters ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Blood Transfusion ☐ Yes ☐ No
Arteriosclerosis ☐ Yes ☐ No	Cosmetic Surgery ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No
Mitro Valve Prolapse ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Anemia ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Chronic Cough ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Heart Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Bruise Easily ☐ Yes ☐ No
Heart Surgery ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Allergies or Hives ☐ Yes ☐ No	Epilepsy/Seizures ☐ Yes ☐ No
Rheumatism ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No	Fainting/Dizzy Spells ☐ Yes ☐ No
Cortisone Medicine ☐ Yes ☐ No	Radiation Therapy ☐ Yes ☐ No	Nervousness ☐ Yes ☐ No
Drug Addiction ☐ Yes ☐ No	Chemotherapy ☐ Yes ☐ No	Psychiatric Treatment ☐ Yes ☐ No
Stroke ☐ Yes ☐ No	Hepatitis A (infectious) ☐ Yes ☐ No	Developmentally Disabled ☐ Yes ☐ No

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Do you use more than two pillows to sleep? ☐ Yes ☐ No

Have you lost or gained more than ten pounds in the past year? ☐ Yes ☐ No

Do you ever wake from sleep and feel short of breath? ☐ Yes ☐ No

Do you smoke? If yes, how much? _____ ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No

If yes, please specify _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

CONSENT

1. I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions truthfully and to the best of my knowledge.
2. I acknowledge the importance of keeping reserved appointment times. I understand that failure to give 2 business days notice for non-surgical appointments and 5 business days notice for surgical appointments may result in a cancelation fee being charged to my account.
3. Lastly, I understand that it is my responsibility to advise yuor office of any changes in the information contained on this form.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

Print Form