Patient Information

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to you dental health.

Patient's name_____Birth date_____Home phone_____
Cell phone_____Mailing address_____ City_____
State_____ Zip_____Email address_____
Emergency Contact's Name & Phone#_____
Employer_____ Occupation_____

Spouse's name_____ Spouse's employer_____ ☐ Unmarried
Whom may we thank for referring you to our office?_____
Have you ever seen us online?_____

Billing, Credit, and Insurance Information: ☐ Not covered by dental insurance
Your Social Security number:_____ Dental Insurance Co._____ Group Number_____
Covered by spouse's or parent's insurance?_____
Spouse's dental insurance company_____
Spouse's or parent's birthday_____ Social Security Number_____

Medical Health History

Do you have or have you had any of the following
(Please write yes or no answers)

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 or low 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 disorder_____
Abnormal bleeding after extractions, surgery, or trauma_____
Hayfever or sinus trouble_____
Allergies or hives_____
Asthma_____
Do you smoke or use chewing tobacco?_____

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 narotics_____
Sulfa drugs_____
Barbiturates, sedatives, or sleeping pills_____
Aspirin_____
Other:_____

Are you taking any of the following?

Aspirin_____
Anticoagulants (blood thinners)_____
Antibiotics or sulfa drugs_____
High blood pressure medicine_____
Antidepressants or tranquilizers_____
Insulin, Orinase, or other diabetes drug_____
Nitroglycerine_____
Cortisone or other steroids_____
Osteoporosis (bone density) medicine_____
Other:_____
_____

Women:

May be pregnant_____
Expected delivery date:_____
Taking hormones or contraceptives_____

Name of your physician:_____

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

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

Signature of patient (or parent)_____

Date_____