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 Name: _____ Birth Date: _____ SS #: _____
If Minor, Parent Name(s): _____ Preferred Phone: _____
Secondary Phone: _____ Email Address: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Covered by Dental Insurance? ___ Yes ___ No Insurance Company Name: _____
Policyholder Name: _____ Policyholder Date of Birth: _____
Policy Provider: ___ Retired ___ Self Insured ___ Employer: _____
Group No.: _____ Member ID: _____

****DENTAL INSURANCE CARD MUST BE PRESENTED AT INTIAL VISIT AND/OR WHEN COVERAGE CHANGES.****

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following?
(Please check any that apply and give dates and type.)

___ Cancer: _____
___ Tumor: _____
___ Heart ailment or angina
___ Heart murmur, mitral valve prolapsed, heart defect
___ Rheumatic fever or rheumatic heart disease
___ Artificial joint or valve replacement
___ High or low blood pressure
___ Pacemaker
___ Tuberculosis or other lung problems
___ Kidney disease
___ Hepatitis or other liver disease
___ Alcoholism
___ Blood transfusion
___ Diabetes
___ Neurologic conditions
___ Epilepsy, seizures or fainting spells
___ Arthritis
___ Herpes or cold sores
___ AIDS or HIV positive
___ Migraine headaches or frequent headaches
___ Anemia or blood disorders
___ Abnormal bleeding after extractions, surgery, or trauma
___ Hayfever or sinus trouble
___ Asthma, allergies or hives
___ Other: _____
Do you smoke or use chewing tobacco? ___ Yes ___ No
___ Surgeries: _____
_____
Women: ___ May be Pregnant ---or--- Due Date: _____

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

___ Latex materials
___ Antibiotics: _____
___ Local anesthetics ('Novocain')
___ Codeine or other narcotics: _____
___ Sulfa drugs
___ Barbiturates, sedatives, or sleeping pills
___ Aspirin
___ Other: _____
___ **NO KNOWN ALLERGIES**

Are you taking any of the following?

___ Aspirin
___ Anticoagulants (blood thinners): _____
___ Antibiotics: _____
___ High blood pressure medicine: _____
___ Hormones or contraceptives
___ Antidepressants or tranquilizers: _____
___ Insulin, Metformin, or other diabetes drugs
___ Nitroglycerin
___ Cortisone or other steroids
___ Osteoporosis (bone density) medicine

List any other medications: _____
_____
_____
_____
_____
_____

Name of your Physician: _____ Date of last exam: _____
Please list any disease, condition, or problem not listed: _____

Signature of Patient (or Parent/Guardian): _____ Date: _____