WELCOME

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form.
If you have any questions or need assistance, please ask us!

PATIENT INFORMATION Date

Name: _____ Birthdate: _____ Home Phone (___) _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐M ☐F ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Email: _____ Cell Phone: (____) _____ SSN: _____

If student name of School: _____ City: _____ State: ___ Full time☐ Part Time ☐

Employer: _____Address: _____ Work Phone: (____) _____

Spouse/Parent/Guardian's Name: _____ Number: (___) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: (___) _____Relationship: _____

RESPONSIBLE PARTY

Name of Person
Responsible for this account: _____ Relationship to Patient: _____

Address: _____ Home Phone: (_____) _____

Birthdate: _____ Employer: _____ Currently a patient in the office? ☐Yes ☐ No

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____ Date Employed: _____

Employer: _____ Phone Number: (____) _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Insurance Company: _____ Group #: _____ Group Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

ADDITIONAL INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____ Date Employed: _____

Employer: _____ Phone Number: (____) _____

Insurance Company: _____ Group #: _____ Group Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

OVER ⇨

Medical History

Although dental personnel primarily treat the area 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.

Name: _____ **Phone:** _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician**: _____

			Women	**Y**	**N**
Have you ever been hospitalized or had a major operation?	Yes	No	Are you pregnant or try to get pregnant?	☐	☐
Are you under the care of a physician?	Yes	No	Are you taking contraceptives?	☐	☐
Have you ever had a serious head or neck injury?	Yes	No	Are you Nursing?	☐	☐
Are you taking any medications or supplements?	Yes	No			

If yes, please list the medication, dose, & how often: _____

_____

Do you take, or have you taken Phen-Fen or Redux?	Yes	No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No
Are you on a special diet?	Yes	No
Do you use Tobacco?	Yes	No
Do you use controlled substances?	Yes	No

Are you allergic to any of the following?

☐ Aspirin	☐ Metal
☐ Penicillin	☐ Latex
☐ Local Anesthetics	☐ Sulfa Drugs
☐ Acrylic	☐ Other: _____
☐ Codeine	☐ NONE

CIRCLE ALL THAT APPLY:

FAMILY HISTORY UNKNOWN? ☐ **YES** ☐ **NO**

Acid Reflux	Yes	No	Epilepsy\Seizures	Yes	No	Mitral Val. Prolapse	Yes	No
AIDS\HIV Positive	Yes	No	Excessive Bleeding	Yes	No	Osteoporosis	Yes	No
Alzheimer's Disease	Yes	No	Excessive Thirst	Yes	No	Jaw Pain	Yes	No
Anaphylaxis	Yes	No	Fainting Spells\Dizziness	Yes	No	Parathyroid Disease	Yes	No
Anemia	Yes	No	Frequent Cough	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Radiation Treatments	Yes	No
Arthritis\Gout	Yes	No	Frequent Headaches	Yes	No	**When?** _____		
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Recent Weight Loss	Yes	No
Artificial Joint:	Yes	No	Glaucoma	Yes	No	Renal Dialysis	Yes	No
What Joint? _____			Hay Fever	Yes	No	Rheumatic Fever	Yes	No
When? _____			Heart Attack\Failure	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Shingles	Yes	No
Blood Disease	Yes	No	Heart Pace Maker	Yes	No	Sickle Cell Disease	Yes	No
Blood Transfusion	Yes	No	Heart Trouble\Disease	Yes	No	Sinus Trouble	Yes	No
Breathing Problem	Yes	No	Hemophilia	Yes	No	Sleep Apnea	Yes	No
Bruise Easily	Yes	No	Hepatitis A	Yes	No	**Do you wear a c-pap?**	Yes	No
Cancer	Yes	No	Hepatitis B or C	Yes	No	Spina Bifida	Yes	No
Type? _____			Herpes	Yes	No	Stomach Disease	Yes	No
Chemotherapy	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
When? _____			High Cholesterol	Yes	No	Swelling of Limbs	Yes	No
Chest Pains	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Cold Sores\Fever Blisters	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Congenital Heart Disorder	Yes	No	Inflammatory Disease	Yes	No	Tuberculosis	Yes	No
Convulsions	Yes	No	**Type**? _____			Tumors or Growths	Yes	No
Cortisone Medicine	Yes	No	Irregular Heartbeat	Yes	No	Ulcers	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Venereal Disease	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Yellow Jaundice	Yes	No
Dry Mouth	Yes	No	Liver Disease	Yes	No			
Easily Winded	Yes	No	Low Blood Pressure	Yes	No			
Emphysema	Yes	No	Lung Disease	Yes	No			

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ **YES** ☐ **NO**

If yes, please explain: _____

_____

_____

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 the medical status.

Signature of Patient, Parent, or Guardian: _____ **Date**:_____