Patient Information (CONFIDENTAL)

Date:_____ SSN#_____ Sex: M / F

Name_____ Nickname_____ Birth date_____

Address_____ City_____ State_____ Zip_____

Email (for appointment reminder)_____ Home Phone #_____

Employer_____ Work Phone #_____ Cell #_____

Spouse or Partner Name_____ Employer_____ Work Phone #_____

Full Time Student? Y/ N Name of School_____

Person to contact in case of emergency_____ Phone #_____

Who may we thank for referring you? _____

IF PATIENT IS A MINOR- COMPLETE THIS SECTION

Mother/Guardian:_____ **Father/Guardian** _____

SSN# _____ SSN# _____

Employer _____ Employer_____

Employer Phone #_____ Employer Phone #_____

Insurance Information

Name of Insured:_____ Relationship to Patient:_____

Birth date:_____ **SSN#/SIN**:_____

Insurance Company:_____ Group #_____Policy/ID#_____

Ins. Co. Address:_____ City_____ State_____ Zip_____

Ins. Co. Phone #_____ **EMPLOYER**_____

Additional Insurance
Name of Insured: _____ Relationship to Patient:_____

Birth date:_____ **SSN#/SIN**:_____

Insurance Company_____ Group#_____ Policy/ID#_____

Ins. Co. Address:_____ City_____ State_____ Zip_____

Ins. Co. Phone_____ **EMPLOYER**_____

Previous Dentist:_____ Reason for visit today?_____

Patient Medical History:

	Yes	No
Allergies (seasonal).....	☐	☐
Anemia.....	☐	☐
Arthritis.....	☐	☐
Asthma.....	☐	☐
Cancer.....	☐	☐
Cardiac Pacemaker.....	☐	☐
Chemotherapy	☐	☐
Diabetes.....	☐	☐
Emphysema.....	☐	☐
Epilepsy/Convulsions.....	☐	☐
Fainting.....	☐	☐
Glaucoma.....	☐	☐
Heart Attack.....	☐	☐
Heart Condition.....	☐	☐
Heart Murmur.....	☐	☐
Hemophilia.....	☐	☐
Hepatitis.....	☐	☐
High Blood Pressure.....	☐	☐
HIV/AIDS	☐	☐

	Yes	No
Joint/Artificial Replacement.....	☐	☐
Kidney Disease.....	☐	☐
Liver Disease.....	☐	☐
Low Blood Pressure.....	☐	☐
Mitral Valve Prolapse.....	☐	☐
Osteoporosis.....	☐	☐
Psychiatric Problems/History.....	☐	☐
Radiation Therapy.....	☐	☐
Respiratory Problems.....	☐	☐
Rheumatic Fever.....	☐	☐
Seizures.....	☐	☐
Shingles.....	☐	☐
Sickle Cell Disease.....	☐	☐
Stomach Troubles/Ulcer.....	☐	☐
Stroke.....	☐	☐
Thyroid Problem.....	☐	☐
Tuberculosis.....	☐	☐

Other condition(s) not listed_____
_____

	Yes	No
1. Are you under medical treatment now.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....	☐	☐
If **YES**, please explain_____ _____.		
3. Are you taking any medication(s)? Including non-prescription medicine?.....	☐	☐
If yes, what medication(s) are you taking? _____ _____.		
4. Have you ever taken Fen-Phen/Redux?...	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing Bisphosphonates?	☐	☐
6. **Do you need to be premedicated with Antibiotics prior to dental treatment?..**	☐	☐

	Yes	No
7. Are you allergic to or have you had any reactions to the following?.....		
Dental Anesthetics (e.g. Novocain).	☐	☐
Metals (e.g. nickel, mercury, jewelry)	☐	☐
Latex rubber.....	☐	☐
Codeine.....	☐	☐
Aspirin.....	☐	☐
Erythromycin.....	☐	☐
Sulfa.....	☐	☐
Penicillin or any other antibiotics?....	☐	☐
Other (please list)_____		
8. Do you use tobacco?.....	☐	☐
9. Do you have history of drug/alcohol or controlled substance abuse?.....	☐	☐
10. Do you use controlled substances? (e.g. morphine, vicodin, etc).....	☐	☐
11. Woman only: a). Are you pregnant or think you May be pregnant?.....	☐	☐