

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's name _____	Preferred name _____	Birth date _____
If minor, parents names _____	Home phone _____	Work phone _____
Email _____	Cell phone _____	
Mailing address _____	City _____	State _____ Zip _____
Employer _____	Occupation _____	
Spouse's name _____	Spouse's employer _____	<input type="checkbox"/> Unmarried
Whom may we thank for referring you to our office? _____		<input type="checkbox"/> Phonebook
BILLING, CREDIT, AND INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance		
Your Social Security number: _____	Dental Insurance Co. _____	Group number _____
Covered by spouse's insurance? <input type="checkbox"/> yes <input type="checkbox"/> no	Insurance Co. Phone# _____	
Spouse's dental insurance company _____	Group number _____	
Spouse's birthday _____	Social Security number _____	

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- 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 disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? yes no

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 narcotics
- 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
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine within the past 3 years
- 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 us to know about: _____

Signature of patient (or parent) _____ Date _____