

# PATIENT INFORMATION



Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ State: \_\_\_\_\_

SS #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's name & phone #: \_\_\_\_\_ Emergency phone# (other than spouse) \_\_\_\_\_

Primary dental insurance: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscribers name: \_\_\_\_\_ Subscribers birth date \_\_\_\_\_ SS# \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscribers name: \_\_\_\_\_ Subscribers birth date \_\_\_\_\_ SS# \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

## MEDICAL HEALTH HISTORY *Do you or have you had, any of the following?*

	Yes	No		Yes	No
Heart Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rashes.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Taking allergy medication.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain or loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Special diet.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>			
Blood disease (anemia).....	<input type="checkbox"/>	<input type="checkbox"/>			
Ever require a blood transfusion?.....	<input type="checkbox"/>	<input type="checkbox"/>			

**Please complete other side**

- Bone or Joint Problems.....
- Arthritis.....
- Back or neck pain.....
- Joint replacement.....
- (e.g., total hips, pins or implants)
- Fainting spells, Seizures, or Epilepsy.....
- Stroke(s).....
- Frequent or severe headaches.....
- Thyroid Problems.....
- Persistent cough or swollen glands.....
- Premedication required by physician or surgeon.....**
- Cancer/Tumor.....

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

	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Diabetes.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinate more than 6 times a day.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Thirsty or mouth is dry much of the time.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis or other respiratory disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how much? _____   |                          |                          |
| Do you smoke?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how much? _____   |                          |                          |
| Hepatitis, jaundice, or liver trouble.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes or other STD.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV-positive/AIDS.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear contact lenses?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| History of head injury?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy of other neurological disease?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| History of alcohol or drug abuse?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any disease, condition, or problem not listed<br>Previously that you feel we should know about?<br>If so, please describe: _____ |                          |                          |

**During the past 12 months, have you taken any of the following?**

	Yes	No
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (Steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
_____		
_____		

**WOMEN**

	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms?		
_____		

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient/Parent Signature \_\_\_\_\_  
 Dentist Initial \_\_\_\_\_ Date \_\_\_\_\_

History Review

\_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_