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
Heart Problems	❑	❑
Chest Pain	❑	❑
Shortness of breath	❑	❑
Blood pressure problems	❑	❑
Heart murmur	❑	❑
Heart valve problem	❑	❑
Taking heart medication	❑	❑
Rheumatic fever	❑	❑
Pacemaker	❑	❑
Artificial heart valve	❑	❑
Blood Problems	❑	❑
Easy bruising	❑	❑
Frequent nosebleeds	❑	❑
Abnormal bleeding	❑	❑
Blood disease (anemia)	❑	❑
Ever require a blood transfusion?	❑	❑

	Yes	No
Allergy Problems	❑	❑
Hay Fever	❑	❑
Sinus Problems	❑	❑
Skin Rashes	❑	❑
Taking allergy medication	❑	❑
Asthma	❑	❑
Intestinal Problems	❑	❑
Ulcers	❑	❑
Weight gain or loss	❑	❑
Special diet	❑	❑
Constipation/Diarrhea	❑	❑
Kidney or bladder problems	❑	❑

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")	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates, sedatives or sleeping pills	❑	❑
Aspirin, Acetaminophen or Ibuprofen	❑	❑
Codeine, Demerol, or other narcotics	❑	❑
Reaction to metals	❑	❑
Latex or rubber dam	❑	❑

Other_____

Notes_____
_____
_____ Date: _____

	Yes	No
Diabetes.....	❑	❑
Urinate more than 6 times a day.....	❑	❑
Thirsty or mouth is dry much of the time.....	❑	❑
Family history of diabetes.....	❑	❑
Tuberculosis or other respiratory disease.....	❑	❑
Do you drink alchohol?	❑	❑
If so, how much?_____		
Do you smoke?.....	❑	❑
If so, how much?_____		
Hepatitis, jaundice, or liver trouble.....	❑	❑
Herpes or other STD.....	❑	❑
HIV-positive/AIDS.....	❑	❑
Glaucoma.....	❑	❑
Do you wear contact lenses?.....	❑	❑
History of head injury?.....	❑	❑
Epilepsy of other neurological disease?.....	❑	❑
History of alcohol or drug abuse?.....	❑	❑

Do you have any disease, condition, or problem not listed Previously that you feel we should know about?
If so, please describe:_____

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

	Yes	No
Antibiotics or sulfa drugs	❑	❑
Anticoagulants (e.g., Coumadin)	❑	❑
High blood pressure medicine	❑	❑
Tranquilizers	❑	❑
Insulin, Orinase, or similar drug	❑	❑
Aspirin	❑	❑
Digitalis or drugs for heart trouble	❑	❑
Nitroglycerin	❑	❑
Cortisone (Steroids)	❑	❑
Natural remedies	❑	❑
Nonprescription drug/supplements	❑	❑

Other_____
_____

WOMEN	Yes	No
Are you taking contraceptives or other hormones?	❑	❑
Are you pregnant?	❑	❑
If so, expected delivery date:_____		
Are you nursing?	❑	❑
Have you reached menopause?	❑	❑
If so, do you have any symptoms?		

_____

Notes:_____
_____
_____

Patient/Parent Signature
_____
Dentist Initial_____ Date_____

History Review

_____
Dentist Signature Date