Patient Information

Today's Date:____________________
Patient Name:____
How would you prefer to be addressed:__________________________________
Address:____
City:______________________ State:___________Zip:________
Home Phone:_________________________ Cellular Phone:______________
Birthdate:_________________Age:______ Male/Female:__________
Social Security#:_____________________ E-mail:__________________________
Employed By:__________________________________Occupation: ___________
Business Phone:_________________ Ext: ____________
Circle One: Married Student Single Divorced Widowed
Name of Spouse:__________________________________
Dental Insurance: Yes No
If Yes, Name of Insurance Co.:____
If completing this form for someone else, Name & Relationship to patient:
____

Getting Acquainted

When was your last Physical exam?_________________
Name & Address of your Physician: ______________________________________
____
Has there been any change in your general health within the last year?__________
If yes, please explain:____
Any serious trouble or bleeding associated with past dental work?_________
If yes, please explain:____
When was your last dental visit/check-up?_________________
Do you have any medical condition or have you ever been advised by your physician that you need to be pre-medicated for routine dental work? __________
Please list any medications you are currently taking:__________________________
____
____
Name of Closest relative not living with you: _______________________________
Address: _______________________City:___________State:______Zip:________
Phone: ____________________Relationship to this person:____________________
Whom may we thank for referring you? ___________________________________

Thank you for choosing our office for your Dental needs. We are committed to providing you with the highest quality of care available today.

MEDICAL HISTORY

Patient Name____

Although dental personnel primarily treat the area in and 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.

Are you under a physician's care now? O Yes O No Condition being treated:______________________________

Have you ever been hospitalized/had major surgery? O Yes O No______________________________

Have you ever had a serious head/neck injury? O Yes O No______________________________

Are you taking any medications, pills or drugs? O Yes O No______________________________

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No

Do you use tobacco? O Yes O No

Do you take, or have you taken drugs to increase bone density such as: Aredia, Zometa, Fosomax or Actonel? O Yes O No

Do you use controlled substances? O Yes O No

Women: Are you O Pregnant? O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other____________________

Do you have, or have you had, any of the following?

O AIDS/HIV Positive	O Chest Pains	O Frequent Headaches	O Irregular Heartbeat	O Scarlet Fever
O Alzheimer's Disease	O Cold Sores/Fever Blisters	O Genital Herpes	O Kidney Problems	O Shingles
O Anaphylaxis	O Congenital Heart Disorder	O Glaucoma	O Leukemia	O Sickle Cell Disease
O Anemia	O Convulsions	O Hay Fever	O Liver Disease	O Sinus Trouble
O Angina	O Cortisone Medicine	O Heart Attack/Failure	O Low Blood Pressure	O Spina Bifida
O Arthritis/Gout	O Diabetes	O Heart Murmur*	O Lung Disease	O Stomach Disease
O Artificial Heart Valve*	O Drug Addiction	O Heart Pace Maker*	O Mitral Valve Prolapse*	O Stroke
O Artificial Joint*	O Easily Winded	O Heart Trouble/Disease	O Pain in jaw joint	O Swelling of Limbs
O Asthma	O Emphysema	O Hemophilia	O Parathyroid Disease	O Thyroid Disease
O Blood Disease	O Epilepsy or Seizures	O Hepatitis A	O Psychiatric Care	O Tonsillitis
O Blood Transfusion	O Excessive Bleeding	O Hepatitis B or C	O Radiation Treatments	O Tuberculosis
O Breathing Problems	O Excessive Thirst	O Herpes	O Recent Weight Loss	O Tumors/Growths
O Bruise Easily	O Fainting/Dizziness	O High Blood Pressure	O Renal Dialysis	O Ulcers
O Cancer	O Frequent Cough	O Hives or Rash	O Rheumatic Fever*	O Venereal Disease
O Chemotherapy	O Frequent Diarrhea	O Hypoglycemia	O Rheumatism	O Yellow Jaundice
O Osteoporosis				

*Condition may require medication

Have you ever had any serious illness not listed above? O Yes O No ______________________________

Comments: ____

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 medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE