Patient Information

1. Date:________________

Patient:____ Preferred Name______________________
Last First MI

Address____ E-Mail Address______________________
Street City, State, Zip Code

SS#________________ Birthdate:_____/_____/______ Martial Status:________ Sex: ❑ Male ❑Female

Home Phone #:__________________ Cell Phone #:_______________ Work Phone #:__________________

Employer:_______________________________ Address____

Spouse:______________________________ Spouses Employer:____________________

Spouses Contact #______________________________

IMPORTANT: Who may we thank for referring you? ❑ Phone Book ❑ Relative/Friend/Co-worker

Name:________________________

2. **Responsible Party / Insurance Info**

Name:____Home:________________ Work:_______________
Last First MI

Birthdate:_____/_____/_________ SS#_______________________ Cell Phone #:____________________

Address____
Street City State Zip Code

Employer:____________________ Address_____________________________ Phone___________________

Insurance Co. Name___________________________________ Address__________________________

Group and or policy number____

3. **Secondary Insurance Coverage**

Subscriber Name and Address____

SS#_________________________ Date of Birth____________________

Relationship to Patient____

Employer____

Insurance Co. and Address____

Group and/or Policy ID #_____________________________________

4. Phone number you would like us to use when confirming appointment:________________________________

Name of contact at this number, if other than patient:__________________________________

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED?______________________________
Name Phone

CLOSEST RELATIVE NOT LIVING WITH YOU_________________________________
Name Phone

Medical History

Patient Name________________________________ Medical Alerts__________________________________

1. Physician's Name_____________________________ Phone Number___________________________

2. Have you ever been under the care of a medical doctor during the past two years?___________________

   If, yes for what____

   ____

   Physician's Name_____________________________ Phone Number___________________________

3. Are you taking any medication at this time?________ If yes, please list name and dosages________________

4. Are you allergic to any medication or substance?________ If yes, please list__________________________

5. Have you been a patient in the hospital during the past five years?____________________________________

6. Indicate which of the following you have had, or have at present.

   (Check boxes that apply, if yes explain briefly.)

Yes	No		Yes	No	
❑	❑	Heart Problems	❑	❑	Hepatitis A, B, or C
❑	❑	Heart Murmur	❑	❑	Aspirin therapy
❑	❑	Rheumatic fever	❑	❑	Blood transfusion
❑	❑	Artificial heart valves or joints	❑	❑	Anemia
❑	❑	Stroke	❑	❑	Coumadin/Blood Thinners
❑	❑	High Blood Pressure	❑	❑	Bleeding disorders
❑	❑	Low Blood Pressure	❑	❑	Jaundice or liver disease
❑	❑	Diabetes	❑	❑	Hemophilia
❑	❑	Cancer	❑	❑	Epilepsy or seizures
❑	❑	Radiation treatment	❑	❑	Psychiatric care
❑	❑	Chemo Therapy	❑	❑	Latex sensitivity
❑	❑	Lung Disease	❑	❑	Allergies to anesthetics
❑	❑	Respiratory disease	❑	❑	Allergies to medicine or drugs
❑	❑	Asthma	❑	❑	Chemical dependency
❑	❑	Circulatory problems	❑	❑	Swollen neck
❑	❑	Tuberculosis	❑	❑	Sinus problems
❑	❑	Immunosuppressive disease	❑	❑	Ulcer
❑	❑	Venereal disease	❑	❑	Arthitis
❑	❑	HIV_____ AIDS_____	❑	❑	Vertigo

7. Do you have or have you had any disease, condition, or problem not listed?_____________________________

   If yes, please list____

8. Women are you Pregnant? Yes No Months Along?____ Nursing?____ Taking Birth Control Pills?_____

9. Have you ever been told that you need to premedicate with antibiotics prior to dental appointments?_____________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Parent/Guardian Signature_____________________________________ Date_________________________