Patient Information

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ Age _____ Sex ☐ Male ☐ Female I prefer to be called _____

S.S.N. / S.I.N. _____ Home Phone _____ Cell _____

Email Address _____

Patient Address _____

City _____ State _____ Zip _____

Sports/Hobbies _____

Patient's Present Weight _____lbs Height _____ft. _____ in.

Custodial Parent(s) or Guardian(s) _____

Phone (if different than patient's) _____ Cell _____

Address (if different than patient's) _____

City _____ State _____ Zip _____

PREVIOUS DENTIST INFORMATION

Name of Patient's Dentist _____ Phone _____

Dentist's Address _____

City _____ State _____ Zip _____

Date Last Seen _____ Reason _____

Name of Patient's Physician(s) _____

Phone Number(s) _____

Primary Physician's Address _____

City _____ State _____ Zip _____

Date Last Seen _____ Reason _____

RESPONSIBLE PARTY INFORMATION *(If Not Patient)*

Last Name _____ First Name _____ Middle Initial _____

Address (if different than patient's) _____

City _____ State _____ Zip _____

Phone (if different than patient's) _____ S.S.N. / S.I.N. _____

Employer _____ Years with Employer _____

DENTAL INSURANCE INFORMATION

Coverage for Dental Treatment? ☐ Yes ☐ No Coverage for Orthodontic Treatment? ☐ Yes ☐ No

Primary Policy Holder's Name _____ S.S.N. / S.I.N. _____

Birth Date _____ Employed By _____

Dental Insurance Company _____ Group Number _____

Secondary Policy Holder's Name _____ S.S.N. / S.I.N. _____

Birth Date _____ Employed By _____

Dental Insurance Company _____ Group Number _____

Medical Insurance Company _____ Group Number _____

Medical History

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?	☐ Yes ☐ No	If yes, please explain	_____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain	_____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, please explain	_____
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If yes, please explain	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, what?	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, what?	_____
Are you on a special diet?	☐ Yes ☐ No	If yes, what?	_____
Do you use tobacco?	☐ Yes ☐ No	If yes, what?	_____
Do you use controlled substances?	☐ Yes ☐ No	If yes, what?	_____

Are you a woman who is... ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other _____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ No Known Allergies

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, _____

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