

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information is important to your dental health. *Please complete all attached forms.*

NAME _____ Preferred name: _____

Date of Birth _____ SSN _____ Cell Phone: _____ Text Messages: Y / N

Mailing address _____

City _____ State _____ Zip _____

Email address: _____

EMPLOYER _____ OCCUPATION _____

Dental Insurance _____ ID# _____ GROUP _____

Name of your Primary Care Physician (PCP): _____

Name of pharmacy: _____ City/State: _____

Person Responsible for payment if not you: _____ Relationship to you _____

Name of Secondary Dental Insurance _____ ID# _____ GROUP _____

Spouse's Name _____ EMPLOYER _____

Spouse's date of birth _____ SSN# _____

In case of emergency, who would you like us to contact: _____

Dental disease is a combination of many factors; it's necessary to investigate any possible contributing factors

Please answer the following questions the best you can:

GENERAL HEALTH (please circle) Excellent Good Fair Poor

Have you taken any pain meds in the last week? Please circle: ASPIRIN MOTRIN TYLENOL OTHER Current list of

all medications you are taking: _____

**** ALLERGIC TO: LATEX ASPIRIN SULFA PENICILLIN / OTHER ANTIBIOTICS CODEINE NOVACAIN

Please list allergies to other medications: _____

Do you smoke? YES / NO *If yes, how many a day? _____ Prolonged Bleeding? YES / NO

Have you ever been or in treatment with RADIATION / CHEMOTHERAPY? YES / NO

Have you had a joint replacement surgery? Yes / No *If yes please tell us when and what type of surgery you had. _____

Do you take any Pre-Medication antibiotic? Yes / No If yes what are you taking. _____

Please circle any of the listed conditions you may have

Acid Reflux	Depression	Mitral Valve Prolapse
Alcohol Sensitivity	Eating Disorder	Multiple Sclerosis
ALS	Epilepsy / Seizures	Neurological Disorders
Alzheimer's	Fainting / Dizzy	Organ Transplant recipient
Anemia	Fibromyalgia	Osteoporosis
Anxiety/Panic Attacks	Headaches / Mlgraines	Pace Maker / Defibrillator
Arthritis	Heart Attack	Parkinson's Disease
Asthma or Hay Fever	Heart Murmur	Rheumatic / Scarlet Fever
Bell's Palsy	Hepatitis	Sinus Trouble
Blood Clots	High / Low Blood Pressure	Sleep Apnea
Cancer	HIV / Aids	Stroke
Cerebral Palsy	Huntington's Disease	Thyroid Issues
Chemical Dependency	Jaundice / Liver Disease	Tuberculosis
Cold Sores	Joint replacement	Ulcers
Congenital Heart Disease	Leukemia	Vitamin Deficiency
Diabetes 1 or 2	Liver Disease	Vertigo
Dialysis / Kidney Disease	Lupus	Weight loss surgery

Do you have any health conditions not listed above? _____

*** Are you pregnant? YES / NO *** DUE DATE _____

*** Birth control, hormones or contraceptives? YES / NO *** If yes, what kind? _____

Do you have any oral health concerns? Dry mouth / staining / how your smile looks. Tell us more:

** I certify that this health history is correct and I consent for the Patient named above to receive all necessary treatment. I understand that the proposed treatment will be explained to me by all the dental personnel and I have read and fully understand the H.I.P.P.A., Privacy Act.*

Patient, Parent or Guardian Signature & Date