PATIENT INFORMATION DATE_____

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

Patient's Name: _____ Preferred Name: _____ DOB: _____

If minor, parent's names: _____

Home phone_____ Cell phone, _____Work phone, _____
[Our office confirms all appointments by text so please supply the preferred contact number]
Preferred #_____

Mailing address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Patient's Social Security # _____

Emergency contact: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Whom may we thank for referring you to our office? _____

E-Mail: _____

Insurance Information: Covered by Insurance: ☐ Yes or No ☐ Subscriber's DOB _____

Subscriber's Employment _____

Subscriber's SS# _____ Dental Insurance Company: _____

Subscriber's Name: _____Group # _____ Patient's SS# _____

PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD AND DRIVER'S LICENSE SO, A COPY CAN BE MADE

Name of your Physician: _____

Patient Name: _____

PLEASE LIST ALL PRESCRIPTION MEDICIATIONS AND OVER THE COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING.

If you have a list of your prescriptions please give to the front desk so a copy can be made

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

MEDICAL HEALTH HISTORY

Please check or circle to all that apply

- ☐ Cancer or Tumor
- ☐ Heart Ailment or Angina
- ☐ Heart murmur, Mitral Valve prolapse, Heart Defect
- ☐ Rheumatic Fever or Rheumatic heart disease
- ☐ Artificial joint or valve; What kind_____ Year_____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Tuberculosis or COPD
- ☐ Kidney disease
- ☐ Abnormal bleeding after extractions, surgery or trauma
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Do you smoke or use tobacco? Please circle which applies
- ☐ Osteoporosis
- ☐ Neuropathy
- ☐ Multiple Sclerosis
- ☐ Blood transfusion
- ☐ Diabetes – Please list last A1C _____
- ☐ Dementia or Alzheimer's
- ☐ Epilepsy, Seizures, or fainting spells
- ☐ Emotional conditions, depression
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraines
- ☐ Anemia
- ☐ Hay fever or /sinus issues
- ☐ Seasonal allergies or hives
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Anticoagulants – Blood thinners
- ☐ Parkinson's
- ☐ Transplant

What kind of transplant? _____Year_____

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Barbiturates, sedatives, or sleeping pill
- ☐ Local anesthetics [Novocain or Lidocaine]
- ☐ Codeine or other narcotics
- ☐ Sulfa
- ☐ Penicillin
- ☐ Aspirin
- ☐ Metal Sensitivity

Other: _____

Women:

☐ **May be pregnant? Expected delivery date_____**

Please add anything else that you would like us to know about:

_____