Patient Information

Name:____Date:______________________
Last First MI Preferred Name

Gender: Male Female Married Single Child Other________________

Mailing Address:______________________________City___________________State_____Zip__________

Phone (Home):__________________(Work):__________________Ext.________(Cell)__________________

Social Security #:________________________Birth Date:_____________E-mail:________________________

Spouse or Responsible Party Information

Name:____
Last First MI Preferred Name

Gender: Male Female Married Single Child Other______________

Mailing Address:____

Phone (Home):__________________(Work):__________________Ext.________(Cell)__________________

Social Security #:________________________Birth Date:_____________E-mail:________________________

Employment Information

The following is for: the patient the parent

Employer Name:______________________________Phone:________________Ext.__________________

Dental Insurance Information

Primary

Name of Insured:_____________________________________Insured's Phone :______________________
Last First MI

Insured's Address:____

Insured's Birth Date:________________Insured's SS#:__________________ID#:______________________

Insured's Employer:____________________________________Group #:___________________________

Insurance Plan Name:____________________________Insurance Plan Phone #:_________________________

Patient's Relationship to Insured: Self Spouse Child Other

Secondary

Name of Insured:_____________________________________Insured's Phone :______________________
Last First MI

Insured's Address:____

Insured's Birth Date:________________Insured's SS#:__________________ID#:______________________

Insured's Employer:____________________________________Group #:___________________________

Insurance Plan Name:____________________________Insurance Plan Phone #:_________________________

Patient's Relationship to Insured: Self Spouse Child Other

Referral Information

Whom may we thank for referring you to our practice?____

Friend Sign Radio Yellow Pages Newspaper

Health Information

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? □ Yes □ No

Within the past year, have there been any changes in your general health? □ Yes □ No

Your Primary Care Physician (name, address and phone number): ______________________

Please mark any of the following to indicate "Yes" in response to the question:

- □ Have you ever had complications following dental treatment?
- □ Are you currently under the care of a physician due to a specific condition?
- □ Have you been hospitalized within the last 5 years due to a surgery of illness?
- □ Do you use tobacco (smoking or chewing)?
- □ Do you require the use of corrective lenses (contacts or glasses)?
- □ Do you have any other chronic conditions or diseases that we should be aware of?
- □ Have you ever been diagnosed with Osteoporosis (if yes, please list any medications prescribed)?
- □ DO YOU HAVE ANY ARTIFICAL JOINTS OR HEART VALVES?

If any of the previous questions are marked, please explain: ______________________

____

Are you pregnant or trying? □ Yes due date:__________ □ No

Are allergic to any medications? □ Yes list:______________________ □ No

Are you taking any medication now? □ Yes □ No

Please list all prescription, non-prescription, vitamins (if you use a specific pharmacy please note as well):

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Medical Alerts:

Please indicate if you have experienced any of the following:

- □ AIDS
- □ Anemia
- □ Aspirin Allergy
- □ Birth Control
- □ Ceclor Allergy
- □ Codeine Allergy
- □ Demerol Allergy
- □ Epilepsy
- □ Flagyl Allergy
- □ Heart Murmur
- □ Hepatitis A
- □ High Fear
- □ Jaundice
- □ Latex Allergy
- □ Nervous Disorders
- □ On Blood Thinners
- □ Penicillin Allergy
- □ PREMED
- □ Rheumatic Fever
- □ Sleep Apnea
- □ Sulfa Allergy
- □ Ulcers
- □ Allergies
- □ Arthritis
- □ Asthma
- □ Blood Disease
- □ Cipro Allergy
- □ COPD
- □ Diabetes
- □ Epinephrine Allergy
- □ Glaucoma
- □ Heart Surgery
- □ Hepatitis B
- □ High Gag Reflex
- □ Keflex Allergy
- □ Liver Disease
- □ Nitrous Allergy
- □ Osteoporosis
- □ Phenergan Allergy
- □ Radiation Treatment
- □ Rheumatism
- □ Stomach Problems
- □ Thyroid Disease
- □ Amoxicillin Allergy
- □ Artificial Joints
- □ Bactrim Allergy
- □ Cancer
- □ Clindamycin Allergy
- □ Cortisone Allergy
- □ Dizziness/Fainting
- □ Erythromycin Allergy
- □ Heart Disease
- □ Hemophilia
- □ High Blood Pressure
- □ Ibuprofen Allergy
- □ Kidney Disease
- □ MVP
- □ Novocain Allergy
- □ Pacemaker
- □ Pregnant/Nursing
- □ Respiratory Problems
- □ Sinus Problems
- □ Stroke
- □ Tumors