Patient Information

Date_____

Patient's Name_____
Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Minor ( )

Address:_____

City_____State_____Zip_____

Home phone #_____Cell #_____
Employed By:_____Work #_____
Patient's SS#_____Patient's Date of Birth_____
E-mail _____
Spouse's/Parent's Name (if patient is a minor)_____
Whom may we thank for referring you to us?_____
In case of emergency contact_____Ph#_____

Have you or any member of your family been a patient here before? □ Yes □ No

Responsible Party

Name of person responsible for this account_____
Relationship to patient_____SS #_____
Address_____City_____
State_____Zip_____Home#_____
Employer_____Work #_____

IF PATIENT IS A MINOR, THE PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT, MUST BE PRESENT AT TIME OF VISIT.

Insurance Information

Name of Insured_____ID#_____
Date of Birth_____Relationship to patient _____
Insurance Co. Name_____ Group #_____
Address_____City_____
State_____Zip_____Phone #_____
Secondary Ins. Co._____Phone#_____

Medical History

Do you or have you ever had?

☐yes ☐no Anemia
☐yes ☐no Diabetes ☐I ☐II
☐yes ☐no HIV Positive
☐yes ☐no Stomach Ailments
☐yes ☐no Ulcer
☐yes ☐no T.B.
☐yes ☐no Thyroid Disease
☐yes ☐no Kidney Disease
☐yes ☐no Liver Disease
☐yes ☐no Hepatitis A/B/C
☐yes ☐no Rheumatic Fever
☐yes ☐no Heart Murmur
☐yes ☐no Mitral Valve Prolapse
☐yes ☐no Heart Valve Replacement
☐yes ☐no High Blood Pressure BP:____
☐yes ☐no Heart Disease (if YES specify; angina, heart attack, stroke etc. and when?)
_____
☐yes ☐no Have you ever taken Phen Fen (or related diet drugs?)

☐yes ☐no Are you currently taking, or have ever taken *bisphosphonates* like; *Fosamax, Actonel, Boniva, Zometa, or Aredia* ?

☐yes ☐no Surgery within last 6 mos. (if YES please specify)

_____

☐yes ☐no Prosthetic joint replacement? When? (specify)

_____

☐yes ☐no Do you take an antibiotic PRIOR to dental visits for, a heart or a diagnosed Medical condition? If Yes, what?_____

☐yes ☐no Are you under the care of a physician now?

Medications currently on_____

_____

☐yes☐no Do you stop a medication before dental treatment such as a blood thinner?

Are you Allergic to?

☐yes ☐no Penicillin
☐yes ☐no Latex
☐yes ☐no Sulfa Drugs
☐yes ☐no Dental Anesthetics (specify):_____
☐yes ☐no Other allergies (specify):_____

Dental History

☐yes ☐no Clicking/Popping jaw
☐yes ☐no Difficulty opening or closing jaw
☐yes ☐no Have had a root canal before? If Yes, How long ago?_____

Women Only

☐yes ☐no Are you pregnant?
If yes, how far along?_____

☐yes ☐no Do you take hormone pills?

☐yes ☐no Do you take birth control pills? (if yes is it for something other than preventing pregnancy? specify:)_____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment. I understand that if it's been 6 months or more since my last visit, an updated form will be necessary.

Patient /Guardian Signature_____ Date_____

Doctor Signature _____ Date_____