PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions, please don't hesitate to ask.

Patient's name ________________________ Preferred name __________ Birth date (month/date/year) __________

If a minor, parents' names __________________ Home phone ________ Work phone ________ Cell phone ________

Preferred Email Address ____

Mailing address ____________________________ City ______________ State _____ Zip ___________

Employer ________________________ Occupation ________________________________

Marital Status: ❑ Married ❑ Unmarried ❑ Divorced ❑ Widowed

Spouse's name ________________________ Spouse's employer ______________________________

Emergency Contact (other than spouse): _________________________ Phone Number: ____________________

How did you hear about our office?

❑ Building Sign/Drove By ❑Website ❑Mailer ❑Event_________ ❑Employee__________ ❑Review Site__________ ❑Current Patient-Whom may we thank? __________

About how long since your last dental appointment?____________ Reason for leaving previous dentist____________________

Current dental concerns? ____

Are your teeth: ❑Sensitive? ❑ Dissatisfied with appearance? ❑ Whiter teeth? ❑Interested in replacing mercury/amalgam/silver fillings?

Feelings regarding dental treatment? ❑Not at all anxious ❑ A little anxious ❑Anxious ❑Very anxious

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ No dental insurance coverage

Your Social Security number or member ID: ____________________ Dental Insurance Co. Name________________

Group number: __________________ Insurance Phone Number __________________

If covered under spouse's policy:

Spouse's dental insurance company name________________ Phone number: ____________ Group number: ___________

Spouse's birthday (month/date/19__): ____________ Spouse's Social Security number or member ID ________________

MEDICAL HEALTH HISTORY

How would you rate your overall general health: ❑Excellent ❑Good ❑Fair ❑Poor Height ________Weight_______

Do you currently have, or have you previously had, any of the following medical conditions? (Please check all that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, or heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________________

Are you currently taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes medications
- ❑ Nitroglycerin or heart medication
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (Fosomax, Skelid, Bonefos) medication
- ❑ Other:______________________________

please list ***ALL*** medications

Women Only:

- ❑ May be pregnant Expected delivery date: __________
- ❑ Nursing
- ❑ Taking hormones or contraceptives

Please explain the current status of any checked boxes:

____

____

Name of your current physician:______________________________ Phone Number: ____________________

Address:____

Please add anything else you would like us to be aware of:

____

____

Signature of patient (or guardian if patient is a minor) : ______________________________ Date: __________