Patient Information

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 ______ Birthdate ______
If minor, parents names ______ Home Phone ______ Cell Phone ______
Mailing Address ______ City ______ State ______ Zip ______
Email Address ______ Driver License / ID Number ______
Employer ______ Occupation ______ Work Phone ______
Insured Information: Insured Name ______ Relationship to Patient ______
Insured Social Security Number ______ Insured Birthdate ______
Dental Insurance Co. ______
Insured Member ID ______ Insured Group Number ______
What brings you in today? ______
What would like to change about your smile? ______
How did you hear about us? ______
Whom may we thank for referring you to our office? ______

Medical Health History

Do you have or have had any of the following?
(please check any that apply)

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

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 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 drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: ______

Are you using any recreational drugs? ☐ Yes ☐ No

Women :

- ☐ May be pregnant
  Expected delivery date: ______
- ☐ Taking hormones or contraceptives

Name of your physician: ______
Do you have any disease, condition, or problem not listed above? ______

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

Signature of patient (or parent/guardian) ______ **Date** ______