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Patient Information

Welcome

Patient Name:_____ **Date:**_____

Cell Phone_____ **Email**_____
Street Address_____ **City**_____ **State**_____ **Zip Code**_____ **Home Phone**_____
Work Phone_____ **Date of Birth**_____ **SS#**_____
If patient is a full-time student, name of school_____
Employer_____ **Address**_____
_____ **City/ State**_____ **Zip Code**_____
In case of emergency, who should be notified?_____ **Phone**_____
Relationship to patient_____
Whom may we thank for referring you?_____

Primary Dental Insurance

Policy Holder_____
Relation to Patient_____ **Date of Birth**_____
Address (if different than patient)_____
City/State_____ **Zip Code**_____ **Policy Holder employed by**_____
Address_____ **City/State**_____ **Zip**_____
SS#_____ **Work Phone**_____
Insurance Company_____ **Group Number**_____
Subscriber #_____ **Insurance Company Address**_____
City/State_____ **Zip Code**_____ **Phone**_____

Secondary Dental Insurance

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**
Policy Holder_____
Relation to Patient_____ **Date of Birth**_____
Address (if different than patient)_____
City/State_____ **Zip Code**_____ **Policy Holder employed by**_____
Address_____ **City/State**_____ **Zip**_____
SS#_____ **Work Phone**_____
Insurance company_____ **Group Number**_____
Subscriber #_____ **Insurance Company Address**_____
City/State_____ **Zip Code**_____ **Phone**_____

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health? _____
☐	☐	☐	Has there been any change in your general health within the past year?_____
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the conditions being treated?_____
			_____ Date of last physical examination? _____
			Physician(s)_____
			NAME PHONE ADDRESS CITY/STATE/ZIP
			_____
			NAME PHONE ADDRESS CITY/STATE/ZIP
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____
			If so, what was the illness or problem? _____
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking?
			Prescribed _____
			Over the counter _____
			Natural or herbal preperations_____

A fee will be charged for an appointment missed if our office is not gived 24 hours notice of cancellation.

_____
Signature – Person Responsible for Account **Date**

Yes	No	Don't Know	
(Women Only)			
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? _____
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?

Name of physician or dentist* _____ Phone _____

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopaedic Surgeons recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with artificial orthopedic prosthetic joints. This office will glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Asthma
☐	☐	☐	Blood transfusion
			If yes, date _____
☐	☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	☐	Cardiovascular disease.
			If yes, specify below:
			○ Angina
			○ Arteriosclerosis
			○ Artificial heart valves
			○ Coronary insufficiency
			○ Coronary occlusion
			○ Damaged heart valves
			○ Heart attack
			○ Heart murmur
			○ High blood pressure
			○ Inborn heart defects
			○ Mitral valve prolapse
			○ Pacemaker
			○ Rheumatic heart disease
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Chronic pain
☐	☐	☐	Persistent diarrhea

Yes	No	Don't Know	
☐	☐	☐	Disease, drug, or radiation-induced immunosurpression
☐	☐	☐	Diabetes. If yes, specify below:
			○ Type I (Insulin dependent)
			○ Type II
☐	☐	☐	Dry mouth
☐	☐	☐	Eating disorder.
			If yes, specify _____
☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	G.E. reflux
☐	☐	☐	Glaucoma
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Recurrent infections
			Indicate type of infection
			_____
☐	☐	☐	Kidney problems
☐	☐	☐	Low blood pressure
☐	☐	☐	Mental health disorders.
			If yes, specify below:
			_____
			_____
☐	☐	☐	Malnutrition
☐	☐	☐	Migraines
☐	☐	☐	Night sweats

Yes	No	Don't Know	
☐	☐	☐	Neurological disorders.
			If yes, specify _____
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in r
☐	☐	☐	Respiratory problems.
			If yes, specify below:
			○ Emphysema,
			○ Bronchitis, etc.
☐	☐	☐	Severe headaches
☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Sores or ulcers in the mouth
☐	☐	☐	Stroke
☐	☐	☐	Systemic lupus erythematosu
☐	☐	☐	Thyroid problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Ulcers
☐	☐	☐	Excessive urination
☐	☐	☐	Do you have any disease, condition, or problem not list above that you think I should know about? Please explain:
			_____
			_____
			_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfactio I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Legal Guardian Date

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay fever/seasonal
☐	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food (Specify) _____
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other (Specify) _____

To yes responses, specify type of reaction _____

Please complete both sides

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signat

Date	Comments	Signature of patient and dentist
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____