PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient Name:

LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2 (APT #)

CITY ST ZIP CODE

HOME:

CELL:

BEST #: Home ☐ CELL ☐

OTHER:

E-Mail:

Referral? ☐ Yes ☐ No Referred by:

Dentist:_____ Phone:_____ Orthodontist_____ Phone:_____

Physician:_____ Phone:_____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:

TOLL-FREE:

FAX:

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:

TOLL-FREE:

FAX:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR PATIENT'S NAME

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ARTIFICIAL HEART VALVE
☐BLEEDING DISORDER
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HIGH BLOOD PRESSURE
☐PACEMAKER
☐STROKE
☐ASTHMA
☐RESPIRATORY DISEASE COPD
☐SINUS PROBLEMS
☐TUBERCULOSIS
☐FREQUENT COLDS
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐RHEUMATIC FEVER
☐AIDS/HIV
☐CANCER/MALIGNANCY
☐DIABETES
☐FREQUENT EAR INFECTIONS
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐RADIATION/CHEMO
☐THYROID CONDITION
☐AUTOIMMUNE DISEASE
☐ADHD
☐DEPRESSION
☐EPILEPSY/SEIZURES
☐ FREQUENT HEADACHES
☐ANXIETY
☐PSYCHIATRIC TREATMENT

☐OTHER – PLEASE LIST: .....

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU **EVER HAD ANY REACTION** TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN ☐CODEINE ☐ANY ANTIBIOTICS ☐SULFA DRUGS ☐NONE
☐LATEX

☐OTHER – PLEASE LIST: .....

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐DAILY ASPIRIN
☐ORAL CONTRACEPTIVES
☐BLOOD PRESSURE MEDICATIONS
☐OSTEOPOROSIS MEDICATIONS
☐TOBACCO
☐RECREATIONAL DRUGS
☐MARIJUANA

DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient's Signature_____ **Date**_____ **Reviewed By**_____