

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:

**IF STUDENT, PLEASE COMPLETE:

FULL-TIME PART-TIME

PARENT/GUARDIAN NAME(S)

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

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

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS | <input type="checkbox"/> TOBACCO |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | | <input type="checkbox"/> MARIJUANA |

DRUG NAME	DOSAGE	REASON PRESCRIBED

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