PATIENT INFORMATION

Patient's name _____Birth date_____

If minor, parents names _____

Mailing address _____ Home Phone:_____

City_____ ST_____ Zip_____ Cell Phone:_____

Employer _____

Occupation_____

Email address_____

Whom may we thank for referring you to our office? _____

BILLING & INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your SSN#: _____ Dental Insurance Co._____Ins Phone #_____

Covered by spouse's insurance? ❑ Yes ❑ No

Spouse's dental insurance company _____ Ins Phone # _____

Spouse's birthday _____ Spouse SSN#_____

MEDICAL HEALTH HISTORY

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

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, 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:_____
- ❑ Liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes
- ❑ Cold Sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Other/Describe_____

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
- ❑ Bisphosphonates (bone density)meds
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Breast Feeding

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Name of your Physician:_____ Phone #_____

Signature of patient (or parent)_____Date_____