PATIENT INFORMATION

Patient's name _____Birth date_____

If minor, parents names _____

Mailing address _____ Home Phone:_____

City_____ ST_____ Zip_____ Cell Phone:_____

Employer (parent)_____

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

Does your child have any health concerns/med conditions that we should be aware of? If so, Please List below.

_____
_____
_____
_____
_____
_____
_____
_____

Last Dental Visit & What was done?

_____
_____
_____

Do you have any specific dental concerns for your child today?

_____
_____
_____
_____
_____

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ 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
- ❑ Other:_____

_____
_____

Name of your Physician:_____ Phone #_____

Signature of patient (or parent)_____Date_____