Patient Information and Health History

Patient Information
Last Name_____ First Name_____ MI_____

Address _____
(Street) (City, State) (Zip)

Home #(_____)_____-_____ Work #(_____)_____-_____ Cell/Pager #(_____)_____-_____

Birth Date _____/_____/_____ Age_____ Sex F M Soc. Sec. #_____-_____-_____
Circle One --- Single Married Divorced Widowed
Email Address:_____
Employer Name and Address_____
Job Title / Occupation_____ Date Started_____

Spouse Information
Last Name_____ First Name_____ MI_____

Address _____
(Street) (City, State) (Zip)

Home #(_____)_____-_____ Work #(_____)_____-_____ Cell/Pager #(_____)_____-_____

Birth Date _____/_____/_____ Age_____ Sex F M Soc. Sec. #_____-_____-_____

Employer Name and Address_____
Job Title / Occupation_____ Date Started_____

Name of closest relative not living with you_____

Relative's Address_____
(Street) (City, State) (Zip)
Relationship_____Home Phone #(_____)_____-_____

Insurance Information
Name of Insured _____
Emloyee SSN_____-_____-_____ Birth Date_____/_____/_____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone #_____ Group #_____
Secondary Insurance Name of Insured _____
Employee SSN_____-_____-_____ Birth Date_____/_____/_____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone #_____ Group #_____

Additional Information
How did you find out about our office? _____
What is the reason for your visit with us today? _____
Are you under the care of a physician at this time? If so, what are you being treated for?_____
Name of Treating Physician_____
Have you ever been required to premedicate with an antibiotic prior to dental work? Y N
Have you been hospitalized within the past year? Y N
If so, what for? _____
Do you use tobacco products? Y N If so, what Kind?_____How often? _____
*Women Only…*Are You or could you be pregnant? Y N If so, when is your due date?_____

Dental History

When was your last visit to a dental office? _____ What was done? _____

Have you ever had a full set of x-rays or a panorex done? Y N If so when? _____

Have you ever been diagnosed with Periodontal Disease? Y N Treatment Completed? Y N

Do your gums bleed? Y N Do You like Your Smile? Y N If no, why not? _____

Is there anything about yourself that you think we should know? _____

Medical Information

Please check any of the following, which you have had or have at present.

___Abnormal Blood Pressure
___AIDS
___Allergies
___Anemia
___Angina
___Arthritis
___Artificial Heart Valve
___Artificial Joint(s)
___Asthma
___Blood Disorders
___Blood Pressure (HIGH)
___Blood Pressure (LOW)
___Blood Transfusion
___Bruise Easily
___Cancer
___Chemotherapy
___Chronic Cough
___Cold Sores
___Congenital Heart Disease
___Congestive Heart Failure
___Cortisone Medication
___Cosmetic Surgery
___Diabetes
___Drug Dependency
___Epilepsy
___Fainting Spells
___Glaucoma
___Heart Disease/Attack
___Heart Murmur
___Heart Pacemaker
___Heart Surgery
___Hemophilia
___Hepatitis A(Infectious)
___Hepatitis B(Serum)
___Herpes
___HIV Positive
___Jaundice
___Kidney Problems
___Leukemia
___Liver Disease
___Meningitis
___Mitral Valve Prolapse
___Organ Transplant
___Polio
___Psychiatric Treatment
___Radiation Therapy
___Rheumatic Fever
___Rheumatism
___Scarlet Fever
___Seizures
___Sickle Cell Disease
___Sinus Trouble
___Stroke
___Thyroid Disease
___TMJ (Pain in Jaw Joints)
___Tuberculosis
___Ulcers
___Venereal Disease
___X-ray/Cobalt Treatment

Other(PleaseIndicate)_____

Are you currently taking any medication Y N If So, Please List: _____

_____

Are You Allergic Or Have You Reacted Adversely To

Local Anesthetics (Novocaine/Xylocaine) Y N
Aspirin Y N
Sulfa Drugs Y N
Codeine Y N
Other Narcotics Y N
Please List_____
Penicillin Y N
Other Antibiotics Y N

Please List _____
Metals Or Jewelry Y N
Latex Y N
Other Allergies Please List _____
_____
_____
_____

Please Read Carefully And Sign

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in any of this information, I will inform the office at the next appointment. I do hereby authorize any dental service or procedure the doctor may deem necessary, for the above named patient or myself. I also authorize the administration of those local anesthetics or premedications which may be deemed advisable. I will be responsible for any financial obligation for treatment for myself or for the above named patient.

X_____ _____ ___/___/___

Signature of Responsible Party Relationship Date

_____

Staff Member Signature