

PATIENT INFORMATION FORM

Date: ____ / ____ / ____

Patient's Name: _____
Last First M.I.

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Social Security #: _____

Occupation: _____

Employed By: _____

Work Address: _____

Single: _____ Married: _____ Separated: _____ Divorced: _____

Referred By: _____

Person Responsible for this Account: _____

Parent/Spouse Information:

Name: _____

Employed By: _____

Work Address: _____

Social Security #: _____

Birthdate: _____

INSURANCE INFORMATION

Do you have dental insurance? Yes: _____ No: _____

Insured through Self, Spouse, or Parent? _____

Name of Insured Person, if not yourself: _____

Name of Insurance Company: _____

Employer's Group #: _____

Patient ID #: _____

Telephone Number of Insurance Company: _____

Mailing Address of Insurance Company: _____

MEDICAL HISTORY

[Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.]

Are you under a physician's care now? Yes ___ No ___ If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes ___ No ___ If yes, please explain _____

Have you ever had a serious head or neck injury? Yes ___ No ___ If yes, please explain _____

Are you taking any medications, pills, or drugs, prescribed or over the counter? Yes ___ No ___

If yes, list here: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes ___ No ___

Are you on a special diet? Yes ___ No ___

Do you use tobacco? Yes ___ No ___

Do you use controlled substances? Yes ___ No ___

Women: Are you

Pregnant or trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic any of the following:

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Local anesthetics

Other

If yes to any, please explain: _____

Do you have, or have you had, any of the following?

AIDs/HIV Positive

Chest Pains

Frequent Headaches

Irregular Heartbeat

Scarlet Fever

Alzheimer's Disease

Cold Sores/Fever Blisters

Genital Herpes

Kidney Problems

Shingles

Anaphylaxis

Congenital Heart Disord.

Glaucoma

Leukemia

Sickle Cell Anemia

Anemia

Convulsions

Hay Fever

Liver Disease

Sinus Trouble

Angina

Cortisone Medicine

Heart Attack/Failure

Low Blood Pressure

Spina Bifida

Arthritis/Gout

Diabetes

Heart Murmur

Lung Disease

Stomach/Intestinal Disease

Artificial Heart Valve

Drug Addiction

Heart Pace Maker

Mitral Valve Prolapse

Stroke

Artificial Joint

Easily Winded

Heart Trouble/Disease

Pain in Jaw Joints

Swelling of Limbs

Asthma

Emphysema

Hemophilia

Parathyroid Disease

Thyroid Disease

Blood Disease

Epilepsy or Seizures

Hepatitis A

Psychiatric Care

Tonsilitis

Blood Transfusion

Excessive Bleeding

Hepatitis B or C

Radiation Treatments

Tuberculosis

Breathing Problem

Excessive Thirst

Herpes

Recent Weight Loss

Tumors or Growths

Bruise Easily

Fainting /Dizziness

High Blood Pressure

Renal Dialysis

Ulcers

Cancer

Frequent Cough

Hives or Rash

Rheumatic Fever

Venereal Disease

Chemotherapy

Frequent Diarrhea

Hypoglycemia

Rheumatism

Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE _____