WELCOME!

Please complete the following Patient Information and Medical History Form in full and bring it with you to your first appointment. We look forward to meeting you!

ABOUT YOU:

NAME: ____________________

HOME ADDRESS: ____________________

____

HOME PHONE: ____________________

WORK PHONE: ____________________

CELL PHONE: ____________________

E-MAIL ADDRESS: ____________________

SS#: ________ - ________ - ________

DOB: ______/______/______

MARITAL STATUS: ____________________

EMPLOYER NAME: ____________________

EMPLOYER ADDRESS: ____________________

____

OCCUPATION: ____________________

SPOUSE INFORMATION:

SPOUSE'S NAME: ____________________

SPOUSE'S EMPLOYER: ____________________

SPOUSE'S SS#: ____________________

SPOUSE'S DOB: ____________________

DENTAL INSURANCE INFORMATION:

SUBSCRIBER NAME: ____________________

RELATION TO PATIENT: ____________________

SUBSCRIBER SS#: ____________________

SUBSCRIBER DOB: ____________________

INSURED EMPLOYER NAME: ____________________

INSURANCE COMPANY NAME AND ADDRESS:

____

GROUP #: ____________________

Member ID #: ____________________

WHERE DID YOU HEAR ABOUT US?
(CHECK AS MANY AS APPLY)

☐ Insurance Provider List ☐ Phone Book

☐ IN Community Magazine ☐ Television

☐ Internet Search

☐ Patient Referral: (name) ____________________

☐ Other: ____________________

TODAYS DATE: ____________________

SIGNATURE: ____________________

Patient Medical History

Physicians Name:	Physicians Phone:
Pharmacy Name:	Pharmacy Phone:
Emergency Contact:	Emergency Contact Phone:

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO ____________

Have you ever had a serious head or neck injury? ☐ YES ☐ NO ____________

Do you have any artificial joints, valves, or implants? ☐ YES ☐ NO ____________

Patients with artificial joints, valves, or implants/prosthetics may require antibiotic pre-medication prior to dental treatment (including cleanings).

Do you require pre-medication for dental work? ☐ YES ☐ NO ____________

Please list any current medications and dosage/instructions:

____

____

Are you allergic to any of the following?

Allergy	YES	NO
Aspirin	☐	☐
Codeine	☐	☐
Dental Anesthetics	☐	☐
Erythromycin	☐	☐
Jewelry	☐	☐
Latex	☐	☐
Metals	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐

Other: ____________

Do you have any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐
Abnormal Bleeding	☐	☐	Drug Addiction	☐	☐	Mitral Valve Prolapse	☐	☐
Alcohol Abuse	☐	☐	Emphysema	☐	☐	Pregnancy or Nursing	☐	☐
Alzheimer's disease	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation Treatments	☐	☐
Angina	☐	☐	Hay fever	☐	☐	Rheumatic Fever	☐	☐
Arthritis/Gout	☐	☐	Heart Attack/Failure	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joint	☐	☐	Heart Pace Maker	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Trouble/Disease	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Hemophilia	☐	☐	Thyroid Disease	☐	☐
Breathing Problem	☐	☐	Hepatitis A	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Hepatitis B or C	☐	☐	Tuberculosis	☐	☐
Cancer-Chemotherapy	☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Hives or Rash	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disorder	☐	☐	Irregular Heartbeat	☐	☐	Yellow Jaundice	☐	☐

Do you use Tobacco? ☐ YES ☐ NO If yes, what kind and how much? ____________

TODAYS DATE: ____________ SIGNATURE: ____________