PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

PATIENT # _____

DATE _____

PATIENT NAME

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE/PROV. _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS #/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
LOCAL ANESTHETICS (EG. NOVOCAINE)	☐	☐	BARBITURATES	☐	☐	ASPIRIN	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐	SEDATIVES	☐	☐	OTHER _____		
SULFA DRUGS	☐	☐	IODINE	☐	☐	_____		

8. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	☐	☐	HEART DISEASE	☐	☐	CHEST PAINS	☐	☐
HEART ATTACK	☐	☐	CARDIAC PACEMAKER	☐	☐	EASILY WINDED	☐	☐
RHEUMATIC FEVER	☐	☐	HEART MURMUR	☐	☐	STROKE	☐	☐
SWOLLEN ANKLES	☐	☐	ANGINA	☐	☐	HAY FEVER / ALLERGIES	☐	☐
FAINTING / SEIZURES	☐	☐	FREQUENTLY TIRED	☐	☐	TUBERCULOSIS	☐	☐
ASTHMA	☐	☐	ANEMIA	☐	☐	RADIATION THERAPY	☐	☐
LOW BLOOD PRESSURE	☐	☐	EMPHYSEMA	☐	☐	GLAUCOMA	☐	☐
EPILEPSY / CONVULSIONS	☐	☐	CANCER	☐	☐	RECENT WEIGHT LOSS	☐	☐
LEUKEMIA	☐	☐	ARTHRITIS	☐	☐	LIVER DISEASE	☐	☐
DIABETES	☐	☐	JOINT REPLACEMENT OR IMPLANT	☐	☐	HEART TROUBLE	☐	☐
KIDNEY DISEASES	☐	☐	HEPATITIS / JAUNDICE	☐	☐	RESPIRATORY PROBLEMS	☐	☐
AIDS OR HIV INFECTION	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	OTHER _____		
THYROID PROBLEM	☐	☐	STOMACH TROUBLES / ULCERS			_____		

COMMENTS

_____

_____

_____

_____

_____

_____

SIGNATURE OF DENTIST DATE

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

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SWOLLEN ANKLES	☐	☐
FAINTING / SEIZURES	☐	☐
ASTHMA	☐	☐
LOW BLOOD PRESSURE	☐	☐
EPILEPSY / CONVULSIONS	☐	☐
LEUKEMIA	☐	☐
DIABETES	☐	☐
KIDNEY DISEASES	☐	☐
AIDS OR HIV INFECTION	☐	☐
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HEART DISEASE	☐	☐
CARDIAC PACEMAKER	☐	☐
HEART MURMUR	☐	☐
ANGINA	☐	☐
FREQUENTLY TIRED	☐	☐
ANEMIA	☐	☐
EMPHYSEMA	☐	☐
CANCER	☐	☐
ARTHRITIS	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
HEPATITIS / JAUNDICE	☐	☐
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STOMACH TROUBLES / ULCERS	☐	☐
CHEST PAINS	☐	☐
EASILY WINDED	☐	☐
STROKE	☐	☐
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