PATIENT INFORMATION

Welcome! Please complete this form, so we may better serve you. Don't hesitate to ask us any questions!

Patient name	Birthdate			
Sex: F/M SSN	Status: □Single □Married □Other			
□Home/□Cell #	E-mail			
Home address				
Emergency contact & number				
Employer/Occupation				
<u>INSURANCE</u>				
Primary dental insurance	Policy holder/subscriber			
Policy holder relationship to patient □Self □Spouse □Child □Other				
Policy holder DOB				
Do you have secondary insurance? ☐ Yes ☐ No	If yes, name			
Do you consent to having a photo of you/patient in your chart for identification? □YES □NO DENTAL HEALTH HISTORY				
Date of last visit to dentist Reason for today's visit				
MEDICAL HEALTH HISTORY				
	Phone number			
Date of last visit to medical doctor				
Are you allergic to any of the following? □Aspirin □Latex □Local Anesthetics □	□Penicillin □Codeine □Acrylic □Metals ☐Other			
Women: Are you? Pregnant/Trying to get pregnant Taking oral contraceptives?	nt? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No ☐ Yes ☐ No			

Abnormal Bleeding	Do you have, or have you had, any of the following? CHECK ANY THAT APPLY.					
Alcohol Abuse		Abnormal Bleeding		Heart Attack/Failure		
Alzheimer's Disease		AIDS/HIV Positive		Heart Murmur		
Anemia		Alcohol Abuse		Heart Trouble/Disease		
Arthritis		Alzheimer's Disease		Hemophilia		
Artificial Joint		Anemia		Hepatitis A		
Artificial Joint		Arthritis		Hepatitis B or C		
Asthma		Artificial Heart Valve		Herpes		
Autoimmune Disease		Artificial Joint		High Blood Pressure		
Blood Disease		Asthma		Hives or Rash		
Blood Transfusion		Autoimmune Disease		Kidney Disease/Problems		
Bronchitis Lung Disease		Blood Disease		Leukemia		
Bruise Easily Mitral Valve Prolapse Cancer Neurological Disorders Neurological Disorders Parathyroid Disease Cold Sores/Fever Blisters Psychiatric Care Congenital Heart Disease Radiation Treatments Convulsions Renal Dialysis Cortisone Medication Rheumatoid Arthritis Depression/Anxiety Shingles Diabetes Skin Disease Skin Disease Emphysema Sinus Trouble Epilepsy or Seizures Stomach/Intestinal Disease Excessive Bleeding Stomach Ulcers Stroke Thyroid Disease Thyroid Disease GERD/Acid Reflux Tuberculosis Glaucoma Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Printed Name Prin		Blood Transfusion		Liver Disease		
Cancer Neurological Disorders Pain in Jaw Joints Chest Pains Parathyroid Disease Cold Sores/Fever Blisters Psychiatric Care Radiation Treatments Conyulsions Renal Dialysis Renal Dialysis Cortisone Medication Rheumatoid Arthritis Depression/Anxiety Shingles Sickle Cell Disease Drug Addiction Sickle Cell Disease Emphysema Sinus Trouble Stomach/Intestinal Disease Excessive Bleeding Stomach Ulcers Stomach Ulcers Frequent Headaches Thyroid Disease GERD/Acid Reflux Tuberculosis Glaucoma Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Printed Name Paint in Justice Printed Name Printed Name Printed Name Paint in Justice Paint in Justice Printed Name Printed		Bronchitis		Lung Disease		
Chemotherapy		Bruise Easily		Mitral Valve Prolapse		
□ Chest Pains □ Parathyroid Disease □ Cold Sores/Fever Blisters □ Psychiatric Care □ Congenital Heart Disease □ Radiation Treatments □ Convulsions □ Renal Dialysis □ Cortisone Medication □ Rheumatoid Arthritis □ Depression/Anxiety □ Shingles □ Diabetes □ Skin Disease □ Drug Addiction □ Sickle Cell Disease □ Emphysema □ Stomach/Intestinal Disease □ Epilepsy or Seizures □ Stomach/Intestinal Disease □ Excessive Bleeding □ Stomach Ulcers □ Fainting spells/Dizziness □ Stroke □ Frequent Headaches □ Thyroid Disease □ GERD/Acid Reflux □ Tuberculosis □ Glaucoma □ Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes ○ No If yes, please explain: □ Please list all the medications you are taking. Printed Name Printed Name		Cancer		Neurological Disorders		
□ Cold Sores/Fever Blisters □ Psychiatric Care □ Congenital Heart Disease □ Radiation Treatments □ Convulsions □ Renal Dialysis □ Cortisone Medication □ Rheumatoid Arthritis □ Depression/Anxiety □ Shingles □ Diabetes □ Skin Disease □ Drug Addiction □ Sickle Cell Disease □ Emphysema □ Stomach/Intestinal Disease □ Excessive Bleeding □ Stomach Ulcers □ Fainting spells/Dizziness □ Stroke □ Frequent Headaches □ Thyroid Disease □ GERD/Acid Reflux □ Tuberculosis □ Glaucoma □ Yellow Jaundice □ Smoker? How many packs/day? Have you ever been hospitalized or had a major operation?		Chemotherapy		Pain in Jaw Joints		
Congenital Heart Disease		Chest Pains		Parathyroid Disease		
Convulsions Renal Dialysis Rheumatoid Arthritis Depression/Anxiety Shingles Skin Disease Diabetes Sickle Cell Disease Drug Addiction Sickle Cell Disease Emphysema Sinus Trouble Epilepsy or Seizures Stomach/Intestinal Disease Fainting spells/Dizziness Stroke Frequent Headaches Thyroid Disease GERD/Acid Reflux Tuberculosis Glaucoma Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Printed Name		Cold Sores/Fever Blisters		Psychiatric Care		
Cortisone Medication Rheumatoid Arthritis Depression/Anxiety Shingles Diabetes Skin Disease Emphysema Sickle Cell Disease Emphysema Sinus Trouble Epilepy or Seizures Stomach/Intestinal Disease Excessive Bleeding Stomach Ulcers Exiniting spells/Dizziness Stroke Frequent Headaches Thyroid Disease GERD/Acid Reflux Tuberculosis Glaucoma Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Printed Name		Congenital Heart Disease		Radiation Treatments		
Depression/Anxiety		Convulsions		Renal Dialysis		
Diabetes Skin Disease Drug Addiction Sickle Cell Disease Emphysema Sinus Trouble Epilepsy or Seizures Stomach/Intestinal Disease Excessive Bleeding Stomach Ulcers Fainting spells/Dizziness Stroke Frequent Headaches Thyroid Disease GERD/Acid Reflux Tuberculosis Glaucoma Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Printed Name Printed Name Printed Name Printed Name Printed Name Printed Name Name Printed		Cortisone Medication		Rheumatoid Arthritis		
□ Drug Addiction □ Sickle Cell Disease □ Emphysema □ Sinus Trouble □ Epilepsy or Seizures □ Stomach/Intestinal Disease □ Excessive Bleeding □ Stomach Ulcers □ Fainting spells/Dizziness □ Stroke □ Frequent Headaches □ Thyroid Disease □ GERD/Acid Reflux □ Tuberculosis □ Glaucoma □ Yellow Jaundice □ Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking. Printed Name		Depression/Anxiety		Shingles		
Emphysema		Diabetes		Skin Disease		
Epilepsy or Seizures Stomach/Intestinal Disease Excessive Bleeding Stomach Ulcers Stroke Fainting spells/Dizziness Stroke Thyroid Disease Thyroid Disease GERD/Acid Reflux Tuberculosis Yellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking.		Drug Addiction		Sickle Cell Disease		
□ Excessive Bleeding □ Stomach Ulcers □ Fainting spells/Dizziness □ Stroke □ Frequent Headaches □ Thyroid Disease □ GERD/Acid Reflux □ Tuberculosis □ Glaucoma □ Yellow Jaundice □ Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking. Printed Name Printed Name		Emphysema		Sinus Trouble		
Fainting spells/Dizziness Stroke Thyroid Disease Tuberculosis Tuberculosis Frequent Headaches Tuberculosis Tuberculosis Fellow Jaundice Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking.		Epilepsy or Seizures		Stomach/Intestinal Disease		
Frequent Headaches		Excessive Bleeding		Stomach Ulcers		
GERD/Acid Reflux Glaucoma Glau		Fainting spells/Dizziness		Stroke		
Glaucoma Glauco		Frequent Headaches		Thyroid Disease		
□ Smoker? How many packs/day? Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking. Printed Name		GERD/Acid Reflux		Tuberculosis		
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking. Printed Name		Glaucoma		Yellow Jaundice		
If yes, please explain: Please list any diseases, conditions, or problems not previously listed. Are you currently taking any medications? If yes, please list all the medications you are taking. Printed Name				Smoker? How many packs/day?		
	If yes, please explain: Please list any diseases, conditions, or problems not previously listed.					
DISLIGITATE DATE		Printed Name		 Date		