

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: Last F	irst Middle Initial		
Street Address			
	State Zipcode		
Primary Phone Cell Phone	Work Phone		
Email Address			
Birthdate/Social Security #	Sex: Male / Female Marital: S / M / D / W		
Employer			
Occupation	No. Years Employed		
In case of an emergency, whom should we contact?	Phone Number		
Who may we thank for referring you to our office?			
If Patient is a minor, give Parent's or Guardian's Name			
DENTAL INSURANCE INFORMATION			
Insured Subscriber Name	Patient Relationship to Subscriber		
Subscriber SS# or Member ID#	Subscriber D.O.B.		
Subscriber's Employer	Group #		
If you have another dental insurance, complete			
Insured Subscriber Name	Patient Relationship to Subscriber		
Subscriber SS# or Member ID#	Subscriber D.O.B.		

Dental History

Physician Name	How long has it b	een since your last den	tal cleaning?	Months	Do you use dental floss	s?	
Medical History Do you have any current health problems? (If yes, please explain) Physician Name Phone Please list all medications that you are taking and dosage Do you smoke? Have you ever smoked? Women Only: Are you pregnant? Nursing? Birth Control Pills? Place A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT: Arthritis	Do your gums bl	eed, or feel tender or ir	ritated?	(please cir	(please circle) Are your teeth sensitive to hot, cold, sweets, pressure		
Do you have any current health problems? (If yes, please explain) Physician Name	Are you happy w	vith the appearance of y	our teeth?	Have y	ou ever worn braces? _		
Do you have any current health problems? (If yes, please explain) Physician Name	Are you aware of	grinding or clenching y	our teeth?	Do you have head	daches, earaches, or nec	:k pains?	
Do you have any current health problems? (If yes, please explain) Physician Name							
Physician Name				-			
Please list all medications that you are taking and dosage Do you smoke?	Do you have any	current health problem	ns? (If yes, please ex	plain)			
Please list all medications that you are taking and dosage Do you smoke?							
Do you smoke?	Physician Name _			Phone			
PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT: Arthritis High Low Blood Pressure Tuberculosis Fainting Tendency Transfusions Fever Blisters Tendency Transfusions Fever Below Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Tendency Transfusions Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Below Fever	Please list all med	dications that you are to	aking and dosage				
PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT: Arthritis High Low Blood Pressure Tuberculosis Fainting Tendency Transfusions Fever Blisters Tendency Transfusions Fever Below Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Tendency Transfusions Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Below Fever							
PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT: Arthritis High Low Blood Pressure Tuberculosis Fainting Tendency Transfusions Fever Blisters Tendency Transfusions Fever Below Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Tendency Transfusions Fever Blisters Tendency Transfusions Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Blisters Fever Below Fever							
PLACE A CHECK NEXT TO ANY OF THE FOLLOWING THAT YOU HAVE OR SUSPECT: Arthritis High Low Blood Pressure Tuberculosis Tendency Transfusions Fever Blisters Tendency Transfusions Fever Blisters Tendency Transfusions List Other Below Heart Disease Short of Breath Attack Short of Breath Attack Bladder Disease Trouble Disease Trouble Disease Blood Thinners Fever Disease Chemotherapy Anemia Glaucoma Blood Thinners Disease Chemotherapy Chemotherapy	Do you smoke? _		Have you ever sm	oked?			
Arthritis High Low Blood Pressure Tuberculosis Fainting Tendency Transfusions Fever Blisters	Women Only: Ar	e you pregnant?		_ Nursing?	Birth Contro	l Pills?	
Arthritis High Low Blood Pressure Tuberculosis Fainting Tendency Transfusions Fever Blisters							
Blood Pressure Diabetes Epilepsy Cortisone Drugs List Other Below	PLACE A CHECK N	NEXT TO ANY OF THE F	OLLOWING THAT YO	OU HAVE OR SUSPECT	<u>i</u>		
Rheumatic Fever Heart Disease/ Attack Short of Breath Attack Heart Murmer Asthma or Hay Fever Mitral Valve Prolapse Artificial Heart Valve Heart Jaundice Heart Below Artificial Heart Valve Heart Sinus Fever Heart Asthma Anemia Fever Artificial Heart Valve Heart Below Artificial Heart Valve Heart Fever Artificial Heart Valve Heart Below Anemia Glaucoma Blood Thinners Chemotherapy Artificial Heart Valve Jaundice Disease Disorders Heart Disease Blood Disease HIV or AIDS Drug Addiction Prosthetic Joint Replacement ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves	Arthritis		Tuberculosis	_		Fever Blisters	
Attack Bladder Trouble Blood Thinners Fever Glaucoma Blood Thinners Fever Blood Thinners Fever Chemotherapy Chemotherapy Chemotherapy Artificial Heart Hepatitis or Joisease Disorders Disease Blood Disease Blood Disease HIV or AIDS Drug Addiction Pacemaker Heart Surgery Cancer or Tumor Bleeding Replacement Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves		+ +	Diabetes	-			
Heart Murmer		Short of Breath	• •		Steroids		
Fever					DI 171		
Prolapse Artificial Heart Valve Jaundice Disease Disorders Heart Liver Disease Blood Disease Heart Surgery Cancer or Tumor Prolonged Bleeding Prosthetic Joint Replacement ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves	Heart Murmer	1 I	Anemia	Glaucoma	Blood Thinners		
Valve Jaundice Disease Disorders Disorders Heart Liver Disease Blood Disease HIV or AIDS Drug Addiction Pacemaker Heart Surgery Cancer or Prolonged Prosthetic Joint Replacement Alcoholism Tumor Bleeding Replacement ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves		Sinus Trouble	Lung Disease	-	Bisphosphonates		
Heart Liver Disease Blood Disease HIV or AIDS Drug Addiction Pacemaker Heart Surgery Cancer or Tumor Prolonged Replacement Alcoholism ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves					Tranquilizers		
Pacemaker Heart Surgery Cancer or Prolonged Prosthetic Joint Alcoholism Tumor Bleeding Replacement ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves					Drug Addiction		
ARE YOU ALLERGIC TO OR DO YOU SUFFER ILL EFFECTS FROM ANY OF THE FOLLOWING? (PLEASE CIRCLE) Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves							
Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves	Heart Surgery		_		Alcoholism		
Penicillin Aspirin Codeine Household Bleach Dental Anesthesia (Epinephrine) Latex Gloves							
		ARE YOU ALLERGIC TO	OR DO YOU SUFFE	R ILL EFFECTS FROM A	INY OF THE FOLLOWING	i? (PLEASE CIRCLE)	
Other	Penicillin	Aspirin Codeir	ne Household	Bleach Dental	Anesthesia (Epinephrine	e) Latex Gloves	
	Other						
I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.	I have reviewed t	the information on this	questionnaire and i	is accurate to the bes	t of my knowledge.		

Date _____

Signature _____