



PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

Employer or School Attending: _____

Address: _____ City: _____ State: _____ Zip: _____

LET US GET TO KNOW YOU

Occupation: _____ Course Study: _____

Referred By: _____ Current Dentist: _____

Favorite Hobby and/or Sport _____

Spouse's Name: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING SECTION

Name of Father: _____ Work #: _____

Employer: _____ Occupation: _____

Name of Mother: _____ Work #: _____

Employer: _____ Occupation: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN SELF OR PARENT)

Person Responsible: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____

INSURANCE INFORMATION

Name of Insured: _____ SSN: _____ Date of Birth: _____

Drivers License #: _____ Name of Employer: _____

Name of Insurance: _____ Group #: _____

Insurance Phone #: _____

MEDICAL HISTORY INFORMATION (CONFIDENTIAL)

Are you currently under a physicians care? Yes No If yes, why _____

Are you taking any medications now, prescription, over the counter and/or illicit drugs (herbal, diet, marijuana, cocaine, methamphetamine, speed, crack, ephedrine, etc)? Yes No If yes, please list all medications:

Date of last physical examination: _____ Date of last blood pressure reading: _____

Height: _____ Weight: _____

Have you been hospitalized in the last 2 years? Yes No If yes, for what purpose:

Have you had any of the following?

- | | | |
|---|--|---|
| <input type="radio"/> Yes <input type="radio"/> No Heart Disease | <input type="radio"/> Yes <input type="radio"/> No Epilepsy | <input type="radio"/> Yes <input type="radio"/> No Stroke |
| <input type="radio"/> Yes <input type="radio"/> No Hepatitis | <input type="radio"/> Yes <input type="radio"/> No Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No Ulcers |
| <input type="radio"/> Yes <input type="radio"/> No Congenital Heart Lesions | <input type="radio"/> Yes <input type="radio"/> No Heart Attack | <input type="radio"/> Yes <input type="radio"/> No Glaucoma |
| <input type="radio"/> Yes <input type="radio"/> No Abnormal Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No Diabetes |
| <input type="radio"/> Yes <input type="radio"/> No Jaundice/Liver Disease | <input type="radio"/> Yes <input type="radio"/> No Asthma | <input type="radio"/> Yes <input type="radio"/> No HIV |
| <input type="radio"/> Yes <input type="radio"/> No Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No Sinus Problems | <input type="radio"/> Yes <input type="radio"/> No Pregnant |

Have you had any joint replacements?

Yes No If so, when? _____ What? _____

Have you ever been treated for venereal diseases (syphilis, gonorrhea or herpes)?

Yes No If so, when? _____

Have you had any blood testing or blood transfusions in the last 2 years?

Yes No If testing, when? _____ Yes No If transfusion, when? _____

Have any reason to believe you have been exposed to HIV?

Yes No If so, when? _____

Have you been treated for alcohol or drug dependency?

Yes No If so, when? _____

Are you allergic to?

- | | | |
|--|---|--|
| <input type="radio"/> Yes <input type="radio"/> No Local Anesthetics | <input type="radio"/> Yes <input type="radio"/> No Penicillin | <input type="radio"/> Yes <input type="radio"/> No Codeine |
| <input type="radio"/> Yes <input type="radio"/> No Nitrous Oxide | <input type="radio"/> Yes <input type="radio"/> No Latex | <input type="radio"/> Yes <input type="radio"/> No Amoxicillin |

Other allergies or drug reactions: _____

Is any other information we should know about the patient's health? _____

Signature of Patient of Guardian

Signature of Dentist