PATIENT INFORMATION AND HEALTH HISTORY

Patient Information
Last Name_____First Name _____ MI _____

Address _____
(Street) (City, State) (ZIP)
Home # (____)_____-_____ Work # (____)_____-_____ Cell # (____)_____-_____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Circle One: Single Married Divorced Widowed EMAIL: _____

Employer Name and Address _____
Job Title/Occupation_____ Date Started _____

Spouse Information
Last Name_____First Name _____ MI _____

Address _____
(Street) (City, State) (ZIP)
Home # (____)_____-_____ Work # (____)_____-_____ Cell # (____)_____-_____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Employer Name and Address _____
Job Title/Occupation_____ Date Started _____

Name of closest relative not living with you _____
Relative's Address _____
(Street) (City, State) (ZIP)
Relationship _____ Home Phone# (____)_____-_____

Insurance Information
Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____ Group # _____
Secondary Insurance Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____ Group # _____

Additional Information
How did you find out about our office? _____
What is the reason for your visit with us today? _____
Are you under the care of a physician at this time? If so, what are you being treated for?_____
_____ Name of Treating Physician _____
Have you ever been required to pre-medicate with an antibiotic prior to dental work? Y ____ N ____
Have you been hospitalized within the past year? Y ____ N ____
If so, what for? _____
Do you use tobacco products? Y ____ N ____ If so, what kind? _____ How often? _____
Women Only…Are you or could you be pregnant? Y ____ N ____ If so, when is your due date? _____

Dental History

When was your last visit to a dental office? _____ What was done? _____
Have you even been diagnosed with Periodontal Disease? Y____ N____ Treatment Completed? Y____ N____
Do your gums bleed? Y____ N____
Is there anything about yourself that you think we should know? _____

Medical Information

Please check any of the following, which you have had or have at present.

_____ Abnormal Blood Pressure
_____ AIDS
_____ Allergies
_____ Anemia
_____ Angina
_____ Arthritis
_____ Artificial Heart Valve
_____ Artificial Joint(s)
_____ Asthma
_____ Blood Disorders
_____ Blood Pressure (HIGH)
_____ Blood Pressure (LOW)
_____ Blood Transfusion
_____ Bruise Easily
_____ Cancer
_____ Chemotherapy
_____ Chronic Cough
_____ Cold Sores
_____ Congenital Heart Disease
_____ Congestive Heart Failure
_____ Cortisone Medication
_____ Cosmetic Surgery
_____ Diabetes
_____ Drug Dependency
_____ Epilepsy
_____ Fainting Spells
_____ Glaucoma
_____ Heart Disease/Attack
_____ Heart Murmur
_____ Heart Pacemaker
_____ Heart Surgery
_____ Hemophilia
_____ Hepatitis A (Infectious)
_____ Hepatitis B (Serum)
_____ Herpes
_____ HIV Positive
_____ Jaundice
_____ Kidney Problems
_____ Leukemia
_____ Liver Disease
_____ Meningitis
_____ Mitral Valve Prolapse
_____ Organ Transplant
_____ Polio
_____ Psychiatric Treatment
_____ Radiation Therapy
_____ Rheumatic Fever
_____ Rheumatism
_____ Scarlet Fever
_____ Seizures
_____ Sickle Cell Disease
_____ Sinus Trouble
_____ Stroke
_____ Thyroid Disease
_____ TMJ (Pain in Jaw Joints)
_____ Tuberculosis
_____ Ulcers
_____ X-ray/Radiation Treatment

Other (Please Indicate) _____

Are you currently taking any medication? Y____ N____ If so, please list: _____
_____

Are you allergic or have you reacted adversely to:

Local Anesthetics	Y____ N____	Other Antibiotics(Penicillin)	Y____ N____
Aspirin	Y____ N____	Please List_____	
Sulfa Drugs	Y____ N____	Metals or	Y____ N____
Codeine	Y____ N____	Latex	Y____ N____
Other Narcotics	Y____ N____	Other Allergies – Please List _____	

Please Read Carefully and Sign

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in any of this information, I will inform the office at the next appointment. I do hereby authorize any dental service or procedure the doctor may deem necessary, for the above named patient or myself. I also authorize the administration of those local anesthetics or pre-medications which may be deemed advisable. I will be responsible for any financial obligation for treatment for myself or for the above named patient.

_____ _____
Signature of Responsible Party Date

_____ _____
Relationship Staff Member Signature