

# PATIENT INFORMATION

# CONFIDENTIAL

DATE \_\_\_\_\_

(PLEASE PRINT)

SS# \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ WOULD YOU LIKE NOTICES SENT BY EMAIL? Y N CELL PHONE \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NAME OF PERSON RESPONSIBLE/INSURED FOR ACCOUNT \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY INSURANCE CO. \_\_\_\_\_ SECONDARY \_\_\_\_\_

## PATIENT MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

- |   |  |                          |                          |                          |                          |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|-----|----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|--|--------------|--|---------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--|-----------|--|-------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------|--|--------|--|-------|--|--------------------------|--------------------------|--------------------------|--------------------------|-------|--|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO<br/>If yes, what medication(s) are you taking? _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Do you use alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Do you use cocaine or other drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>7. Are you allergic to or have you had any reactions to the following?</p> <table border="0"> <tr> <td>YES</td><td>NO</td><td>YES</td><td>NO</td><td>YES</td><td>NO</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Local Anesthetics (eg. novocaine)</td> <td colspan="2">Barbiturates</td> <td colspan="2">Aspirin</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Penicillin or other antibiotics</td> <td colspan="2">Sedatives</td> <td colspan="2">Other</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Sulfa drugs</td> <td colspan="2">Iodine</td> <td colspan="2">_____</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td colspan="2">_____</td> </tr> </table> <p>8. WOMEN ONLY: YES NO</p> <p>a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b) Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c) Are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | YES                      | NO                       | YES                      | NO                       | YES | NO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (eg. novocaine) |  | Barbiturates |  | Aspirin |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotics |  | Sedatives |  | Other |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs |  | Iodine |  | _____ |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |  |
| YES   | NO   | YES                      | NO                       | YES                      | NO                       |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| Local Anesthetics (eg. novocaine)   |  | Barbiturates             |                          | Aspirin                  |                          |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| Penicillin or other antibiotics   |  | Sedatives                |                          | Other                    |                          |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| Sulfa drugs   |  | Iodine                   |                          | _____                    |                          |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |
| <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | _____                    |                          |     |    |                          |                          |                          |                          |                          |                          |                                   |  |              |  |         |  |                          |                          |                          |                          |                          |                          |                                 |  |           |  |       |  |                          |                          |                          |                          |                          |                          |             |  |        |  |       |  |                          |                          |                          |                          |       |  |

9. Do you have or have you had any of the following?

- |  |  |   |
|--|--|---|
| YES NO   | YES NO   | YES NO  |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker            | <input type="checkbox"/> <input type="checkbox"/> Easily Winded                       |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> <input type="checkbox"/> Stroke                              |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever/MVP    | <input type="checkbox"/> <input type="checkbox"/> Frequently Tired             | <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Allergies               |
| <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles         | <input type="checkbox"/> <input type="checkbox"/> Anemia                       | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis                        |
| <input type="checkbox"/> <input type="checkbox"/> Fainting / Seizures    | <input type="checkbox"/> <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy                   |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                 | <input type="checkbox"/> <input type="checkbox"/> Cancer                       | <input type="checkbox"/> <input type="checkbox"/> Glaucoma                            |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss                  |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant | <input type="checkbox"/> <input type="checkbox"/> Liver Disease                       |
| <input type="checkbox"/> <input type="checkbox"/> Leukemia               | <input type="checkbox"/> <input type="checkbox"/> Hepatitis / Jaundice         | <input type="checkbox"/> <input type="checkbox"/> Prescription Weight Loss Medication |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes               | <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems                |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases        | <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles/ Ulcers     | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV Infection  | <input type="checkbox"/> <input type="checkbox"/> Chest Pains/Angina           | <input type="checkbox"/> <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem        |  | _____   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease          |  | _____   |

### COMMENTS

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Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered correctly. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at time of services.

Signature \_\_\_\_\_ Date \_\_\_\_\_