PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ DOB_____

If minor, parents names _____ Cell_____ Work_____Home _____

Email_____ May we leave messages at the above numbers? Y N

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____ Have you visited our website? Y N

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's DOB _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ **Endocarditis**
- ❑ **Heart ailment, defect or cardiac transplant**
- ❑ **Mitral valve prolaps**e
- ❑ **Artificial joint or valve**
- ❑ High or low blood pressure
- ❑ Pacemaker or defibrillator
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Cancer or tumor
- ❑ Epilepsy or seizures
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Anticoagulants (blood thinners)
  __Aspirin (325mg+) __Plavix __Coumadin/Warfarin
  __Ticlid __Xarelto __Heparin __Effient __Arixtra

- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Please describe any impending operations or recent injuries:

_____

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

DENTAL HISTORY

What is the reason for today's visit? _____

When was your last dental visit?_____

How do you feel about the appearance of your teeth? _____

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

- ❑ Bleeding gums
- ❑ Broken fillings
- ❑ Chronic bad breath
- ❑ Food catching between teeth
- ❑ Clenching or grinding of teeth
- ❑ Injury to teeth or jaw
- ❑ Loose teeth
- ❑ Painful or locking jaw
- ❑ Sensitivity to sweet, hot, cold, biting
- ❑ Sores, growths or swelling of mouth
- ❑ Orthodontic treatment
- ❑ Periodontal treatment

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date _____