PATIENT INFORMATION FORM

DATE _____

PATIENT LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____

MAILING ADDRESS: _____

HOMEPHONE: _____ WORKPHONE: _____ CELLPHONE: _____

BEST NUMBER TO CONFIRM APPT. _____ SS# _____ DRIVERS LICENSE # _____

MARITAL STATUS: _____ SEX: M F DOB: _____

SPOUSE _____

EMPLOYER NAME _____ REFERRED BY _____

PARENT/GUARDIAN: (required for all patients under the age of 18)

LAST NAME: _____ FIRST NAME: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ___-___-___ DOB: __/__/__

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ___-___-___ DOB: __/__/__

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____

Name_____
DOB _____

For the following questions, circle yes or no whichever applies. Your answers are for our records and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Have there been any changes in your general health within the past year? ..... Yes No
3. My last physical exam was on _____
4. Are you under the care of a physician? ..... Yes No
   If so, what is the condition treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. *Have you had any serious illness, operation, or been hospitalized in the past 5 years?* ..... *Yes No*
7. *Are you taking any medicine(s) including non-prescription medicine?* ..... *Yes No*
   *If so, please list all medications*_____
8. *Do you have or have you had any of the following diseases or problems?*
   a. *Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease* ..... *Yes No*
   b. *Cardiovascular disease(heart trouble, heart attack angina, coronary occlusion, high blood pressure, arteriosclerosis, stroke)* ..... *Yes No*
      1. *Do you have chest pain upon exertion?* ..... *Yes No*
      2. *Are you ever short of breath after mild exercise or when lying down?* ..... *Yes No*
      3. *Do your ankles swell?* ..... *Yes No*
      4. *Do you have inborn heart defects?* ..... *Yes No*
      5. *Do you have a cardiac pacemaker?* ..... *Yes No*
   c. Allergy ..... Yes No
   d. Sinus trouble ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Persistent diarrhea or recent weight gain ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice, or liver disease ..... Yes No
   j. AIDS, or HIV infection ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis ..... Yes No
   n. Stomach ulcer or hyper acidity ..... Yes No
   o. Kidney trouble ..... Yes No
   p. Tuberculosis ..... Yes No
   r. Persistent swollen glands in neck ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Sexually transmitted disease ..... Yes No
   u. Epilepsy or neurological disease ..... Yes No
   v. Problems with the mental health ..... Yes No
   w. Cancer ..... Yes No
   x. Problems with the immune system ..... Yes No
9. Have you had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No

12. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or other antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates, sedatives or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
    _____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removal dental appliances? ..... Yes No

Women

17. Are you pregnant? ..... Yes No
18. Do you have any problems associated with your menstrual period? ..... Yes No
19. Are you nursing? ..... Yes No
20. Are you taking birth control? ..... Yes No

Chief Dental complaint _____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient
Date_____

For Completion by the dentist:

Comments on patient interview concerning medical history: _____
_____

Significant findings from questionnaire _____

Dental management considerations: _____

_____
Date

_____
Signature of Dentist

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____