

PATIENT INFORMATION FORM

Personal Information

Date: _____
 Dr Mr Mrs Ms Miss
 Name: _____
 Email: _____
 Social Security #: _____
 Street Address: _____
 City: _____
 State: _____ Zip: _____
 Home phone: _____
 Cell phone: _____
 Work phone: _____
 Place of Employment: _____
 Date of Birth: _____
 Male Female Married Single Other

Dental Insurance Information

Primary Insurance Provider: _____
 Policy in the name of: _____
 Policyholder's Date of Birth: _____
 Contract #: _____ Group #: _____
 Secondary Insurance Provider: _____
 Policy in the name of: _____
 Policyholder's Date of Birth: _____
 Contract #: _____ Group #: _____

Medical Insurance Information

Primary Insurance Provider: _____
 Policy in the name of: _____
 Policyholder's Date of Birth: _____
 Contract #: _____ Group #: _____

Dental History

Reason for visit: _____
 Name of Referring Dentist: _____ Date of last visit: _____ Recent X-rays: Yes No
 Have you ever had treatment for gum problems? Yes No _____

Confidential Medical History

Physician's name: _____ Telephone #: _____ Date of last visit: _____
 Are you under a doctor's care now? Yes No _____
 Have you been hospitalized in the last 5 years? Yes No _____
 Do you bleed excessively when cut? Yes No Do you smoke? Yes No
 Do you have allergies? Yes No If so, to what? _____
 Do you need to premedicate prior to dental treatment? Yes No
 Please list medication(s): _____
 Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No
 Taking bisphosphonates? Yes No If yes: Oral IV
 Have you had or do you have any of the following? Please check all that apply:

<input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Anemia
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> HIV+	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Psychiatric Care/Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Malignancy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Radiation or Chemotherapy	<input type="checkbox"/> Artificial Joints or Valves	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Metal Allergy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> TMJ
<input type="checkbox"/> Chemical/Alcohol Dependency	<input type="checkbox"/> Head and Neck Pain		

 Please indicate any other serious illness not indicated above: _____

Informed Consent

I have read, understood and completed accurately the above information. Further, I give permission to the doctors to use anesthetics ("Novocain") as necessary to complete my dental treatment.

Signature: _____ Relationship to Patient: _____ Date: _____