

Patient Information

Patient's Name _____ Date of Birth _____

Mailing Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Do you want a cell phone text reminder or telephone call for future appointments? Yes _____ No _____

E-mail Address _____

Referring Dentist _____ Physician _____

Emergency Contact _____ Phone _____ Relationship _____

Dental Insurance

Primary Ins. Co. _____ Employer _____ Group # _____

Insured Name _____ Insured Birthdate _____ ID or SSN _____

Secondary Ins. Co. _____ Employer _____ Group # _____

Insured Name _____ Insured Birthdate _____ ID or SSN _____

Medical History

Have you had any of the following (please circle):

AIDS-HIV

Alcohol addiction

Anemia

Asthma

Cancer

Congenital heart lesions

Diabetes

Drug addiction

Epilepsy

Frequent headaches

Glaucoma

Heart murmur

Heart valves

Hepatitis

High blood pressure

Jaundice

Low blood pressure

Prosthetic joints

Psychiatric treatment

Rheumatic fever

Sinus trouble

Stroke

Ulcers

Medical History (cont.)

1. Has there been any change in your general health during the past year? _____ Yes ___ No ___
2. Have you been a patient in a hospital in the past two years? _____ Yes ___ No ___
3. Do you require antibiotics prior to any dental treatment? _____ Yes ___ No ___
4. Are you allergic to any medicines? _____ Yes ___ No ___
5. Any excessive bleeding from a cut or tooth extraction? _____ Yes ___ No ___
6. Do you think your teeth are shifting or moving? _____ Yes ___ No ___
7. Do you grind or clench your teeth? _____ Yes ___ No ___
8. Do you smoke? How much per day? _____ Yes ___ No ___
9. Do you use smokeless tobacco products? _____ Yes ___ No ___
10. Do you use synthetic cannabinoids? _____ Yes ___ No ___
11. Do you take any medication for Osteoporosis? _____ Yes ___ No ___

FEMALES ONLY:

1. Are you pregnant? _____ Yes ___ No ___
2. If yes, how many weeks pregnant are you? _____

Please list all your daily medications. Be sure to include blood thinners (Plavix, Coumadin, etc).

