PATIENT INFORMATION

Patient's Name: **Today's Date:**

Address:

City, State, Zip: **Email:**

Home Phone: **Cell Phone:** **Work Phone:**

Birth Date: **Social Security No.:** **Sex:** **Marital Status:**

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Co: **Guarantor's Name** **Birth Date:** **SSN:**

Secondary Dental Insurance Co: **Guarantor's Name** **Birth Date:** **SSN:**

Please present your Dental Insurance Card to the front desk.

HEALTH INFORMATION

Physician Name: **Physician Phone:**

Drug Allergies:	**Latex Allergy?**

Do you or have you ever had any of the following conditions:

- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Heart Bypass
- ☐ Heart Surgery
- ☐ Congenital Heart Defect
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Pace Maker
- ☐ Stent or Shunt
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Hepatitis A, B, C
- ☐ Arthritis
- ☐ Cancer-Chemotherapy
- ☐ Radiation Therapy
- ☐ Tumor
- ☐ Artificial Bone/Joint
- ☐ Organ Transplant
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Fainting Spells
- ☐ Epilepsy
- ☐ Seizures
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Blood Disorder
- ☐ Colitis
- ☐ Ulcers
- ☐ Gastric Reflux
- ☐ Tuberculosis
- ☐ HIV – AIDS
- ☐ Venereal Disease
- ☐ Sinus Problems
- ☐ Allergies/ Hay Fever
- ☐ Headaches – Migraines
- ☐ Depression
- ☐ Anxiety / Nervousness
- ☐ ADHD/ ADD
- ☐ Other _____

If female please answer the following:

Y	N		
☐	☐	Are you taking Birth Control Pills or Injection?	
☐	☐	Are you pregnant?	If Yes, # of weeks?
☐	☐	Are you nursing?	

Height: _____ Weight: _____

Is there any disease, condition, surgery or problem that you think this office should know about not covered previously?

_____

DENTAL HISTORY

Are you having any pain at this time? ----------

If **yes**, please explain: _____

When did you last have your teeth cleaned? _____

Did you have x-rays taken at that time? ----------
Have you required Antibiotics before dental treatment in the past? ----------

If **yes**, please explain: _____

Have you had Braces (orthodontic treatment) in the past? ----------

****Please list All Medications, Supplements and Vitamins on this sheet.****

Medication Name:	**Dosage**