Patient Information

FName: _____ MI: _____ LName: _____

Mailing Address: _____ Birthdate: _____

City/State/Zip: _____ Soc Sec #: _____

Home Phone: _____ Cell Phone: _____ Text reminders? Yes / No

Email: _____ Email reminders? Yes / No

Preferred Contact Method: Home Cell Email Text Other: _____

Responsible Person (if under 18):

FName: _____ MI: _____ LName: _____

Relationship to Patient: _____ Address (if different): _____

DOB: _____ SSN: _____ _____

Phone Number: _____

Insurance Information:

Do you have Dental Insurance: Yes / No?

_____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____

Name of your previous Dentist: _____ Last Visit: _____

Main Dental Concerns: _____

How did you hear about our office? _____

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

	Arthritis		Angina		ALLERGY TO:
	Joint Replacement/Implant		Artificial Heart Valve		Ibuprofen
	Organ Transplant		Heart Attack		Aspirin
	Asthma - Inhaler Yes or No		Heart Lesions		Tylenol
	Emphysema		Heart Murmur		NSAIDS
	Respiratory Problems		High Blood Pressure		Penicillin
	Easily Winded		Low Blood Pressure		Amoxicillin
	Hay Fever/Allergies		Mitral Valve Prolapse		Tetracycline
	Chew/Smoke Tobacco		Pacemaker		Erythromycin
	Cold Sores/Herpes		Rheumatic Fever		Zithromax
	Glaucoma		Heart Disease		Azithromycin
	Stroke		Chest Pains		Hydrocodone
	Epilepsy		Anemia		Codiene
	Dizziness		Hemophilia		Morphine
	Fainting		Blood Disease		Barbituates
	Head Injuries		Blood Transfusion		Sedatives
	Mental Disorders		Blood Clots		Local Anesthetics
	Drug/Alcohol Addiction		Excessive Bleeding		Iodine
	Kidney Disease		Pain/Noise in Jaw Joints		Sulfa Drugs
	Diabetes		Pregnancy: Past or Present		Metals
	Liver Disease		Thyroid Problems		Latex Rubber
	Jaundice		Frequently Tired		NONE
	Hepatitis - A B or C		Recent Weight Loss		Others List Below
	Aids/HIV		Swollen Ankles		
	Venereal Disease		Stomach Problems		
	Sexually Transmitted Diseases		Ulcers		
	Cancer		Radiation Treatment		
	Growths/Tumors		Chemotherapy		
	Leukemia		Other:		
	Tuberculosis		None		

Have you taken any bone density medications such as Fosamax, Boniva or another such as these? Yes / No If yes, which medication? _____

Current Family Physician: _____ Phone Number: _____

Have you ever been instructed to take an antibiotic PREMED for Dental treatment? Yes / No

Current Medications: _____

_____

_____