Patient Information Form

Date_____

Patient Name_____**Age**_____ **Date of Birth**_____

Patient Social Security #_____

Address_____
Street City St Zip

Home #_____**Cell #**_____**Work #**_____

Name of Referring Dentist_____

Name of Nearest Relative_____**Phone#**_____

Address_____
Street City St Zip

Person Financially Responsible for This Account:

Name_____**Phone #**_____

Address_____
Street City St Zip

Insured's Employer_____**Occupation**_____

Primary Dental Insurance_____**Group #**_____

Insured's Name_____**SS#/ID#**_____**Birth date**_____

Secondary Dental Insurance_____**Group #**_____

Insured's Name_____**SS#/ID#**_____**Birth date**_____

Medical History of Patient:

1. Do you consider your health to be: ☐ Good ☐ Fair ☐ Poor

2. Are you currently under a physician's care? ☐Yes ☐No If yes, why?_____

3. Physician's Name_____Phone #_____

4. Please check any of the following conditions that you have now or have had in the past:

☐ Mitral Valve Prolapse	☐ High Blood Pressure	☐ Asthma	☐ Diabetes
☐ Cardiac Pacemaker	☐ Taking Blood Thinners	☐ Sinus Problems	☐ Seizures
☐ Auriculocochlear Implant	☐ HIV or AIDS	☐ Allergies	☐ STDs
☐ Joint Replacement	☐ Hepatitis B or C	☐ Tuberculosis	☐ Substance Abuse
☐ Heart Trouble	☐ Hemophilia	☐ Rheumatic Fever	

5. Please provide any other necessary information about your health including recent surgeries:

_____

6. ***Do you premedicate with an antiobiotic prior to dental procedures due to heart disorders or joint replacements?***
☐ Yes ☐ No *If yes, please list antibiotic and time it was taken today* _____

7. Were you prescribed any medications by your referring dentist? ☐ Yes _____ ☐ No
(Name of medication here)

8. Have you taken a biphosphonate drug (Aredia, Zometa, Fosamax or Boniva) in the last 10 years? ☐ Yes ☐ No

9. Please list any other medications that you are taking:_____

10. Are you currently using stimulant drugs (ie. Ephedra/other diet drugs, Dexedrine, amphetamines or cocaine)? ☐ Yes ☐ No

11. Have you ever had an ***ALLERGIC*** reaction to the following?

		☐ Local Anesthetic	☐ Latex Products
☐ Penicillin or other antibiotic	☐ Aspirin or NSAIDs	☐ Iodine	☐ Codeine or other narcotics

12. (Females only) Are you pregnant? _____Yes _____No