PATIENT INFORMATION (Confidential)

Today's Date_____
Name…… ….Birth date……../……../……SS # / / Sex___
Address …… City..……..…State…….Zip……..
Circle One Single Married Divorced Widowed Separated Child
Home Phone ( )……..-…….. Work Phone ( )……....-……..
Patient's or Parent's employer……
Business Address…… City..……State…….Zip……..
Spouse or Parent's name……Employer…….. Phone ( )……...-……..
Emergency Contact name……..Phone ( )….-…….. name……..Phone ( )….-……..

INSURANCE INFORMATION:
Name of the insurance ……
Name of the policy holder…… Address……
Phone ( )……...-…….. SS # - - - / - - /- - - Group#.....Birth date of Insured…….

PATIENT MEDICAL HISTORY
Physician……..Phone…….……Date of last exam……

1. Are you in good health …..…….yes O no O
2. Are you under treatment now?.....yes O no O
3. Have you had any operation or serious illnesses the past 5 years?.....yes O no O
4. **Are you taking any prescribed medications…yes O no O If yes, what medications_____**
5. **Are you allergic** to any of the following:
   Local Anesthetics (eg. lidocaine)……yes O no O
   Penicillin ……..yes O no O
   other antibiotics……....yes O no O if yes what …….....
   Aspirin…….....yes O no O
   Codeine…..…….....yes O no O
   Other allergy to any other medication…….yes O no O if yes what …….....

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

Congenital Heart Disease……yes O no O
Heart Attack / Surgery…….yes O no O
if yes, Date_____
Prosthetic Heart Valves……...yes O no O
Are you taking Plavix…….…...yes O no O
Are you taking Coumadin……...yes O no O
Are you taking Aspirin……yes O no O
Hip/Joint Replacement or Implants…….yes O no O
if yes, Date_____
Are you taking Fosamx / Biophosphonates
Oral or IV…….…..yes O no O

High Blood Pressure……..……...yes O no O
Cardiac Pacemaker……..……..yes O no O
Asthma…….....yes O no O
Diabetes……yes O no O
Aids or HIV Infection…….....yes O no O
Arthritis…….……....yes O no O
Hepatitis/Jaundice…….....….yes O no O
Stroke……..…….….....yes O no O
Respiratory ……..…….....yes O no O
Epilepsy/Convulsions…….……...…..yes O no O
Other medical condition…….....yes O no O
if yes what _____

WOMEN ONLY:
Are you pregnant or nursing……..yes O no O Are you taking any birth control pills……....yes O no O

PATIENT DENTAL HISTORY.
Do you like your smile .....yes O no O Are you interested in whitening your teeth .....yes O no O
Have you ever had clicking in jaw or pain?.....yes O no O
Do you have any sores or lumps in or near your mouth?.....yes O no O
Do your gums bleed while brushing or flossing……..yes O no O
Have you ever had any difficult extractions in the past?.....yes O no O

HOW DID YOU HEAR OF OUR OFFICE?_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ X _____
Signature of patient (or parent/guardian if minor) Dentists Signature

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