PATIENT INFORMATION

Patient's name ______________________________ Birth date ______________
Preferred name ______________ If minor, parents names ______________
Phone (cell) ______________ E-mail (for confirming appts) ______________
Mailing address ______________ City ______________ State ______ Zip ______
Employer ______________ Occupation ______________
Spouse's name ______________ Spouse's employer ______________ ❑ Unmarried
Emergency Contact ______________ Phone # ______________
How did you hear about our office? ______________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance
Your Social Security number: ______________ Dental Insurance Co. ______________ Group number ______________
Covered by spouse's insurance? ❑ yes ❑ no
Spouse's dental insurance company ______________ Group number ______________
Spouse's birthday ______________ Social Security number ______________

Have you had or currently have any of the following?
(Please check any that apply)

- ❑ Artificial joint, Type ______________
  Month/Year placed ______________
- ❑ Cancer, Type ______________
  Chemo, Month/Year ______________
  Radiation, Month/Year ______________
- ❑ Heart ailment
  - ❑ Angina
  - ❑ Congenital heart defect
  - ❑ High blood pressure
  - ❑ Pacemaker
  - ❑ Previous Infective endocarditis
  - ❑ Other ______________
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Lung ailment
  - ❑ Asthma
  - ❑ COPD
  - ❑ Tuberculosis, Year ______________
- ❑ Kidney disease
  - ❑ Dialysis, Days ______________
- ❑ Hepatitis or other liver disease ______________
- ❑ Diabetes
  - ❑ HbA1c ______________
- ❑ Neurologic condition
  - ❑ Stroke - Type, Month/Year ______________
  - ❑ Epilepsy - Type, Aura ______________
  - ❑ Dementia
  - ❑ Alzheimers
- ❑ Emotional condition ______________
- ❑ Blood Disorder
  - ❑ AIDS or HIV positive
  - ❑ Other ______________
- ❑ Sleep Disorder
  - ❑ Obstructive Sleep Apnea
    - ❑ Use a CPAP
  - ❑ Other ______________
- ❑ Nicotine product use
  - ❑ Cigarettes or Cigars, #/day ______
  - ❑ E. Cig or Vape
  - ❑ Smokeless Tobacco
- ❑ Pregnant / May be pregnant
  - ❑ Expected delivery date: ______________
- ❑ Any condition not listed ______________

Are you allergic to, or have you reacted adversely to any of the following:

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other Antibiotic ______________
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Other: ______________

Are you taking any of the following? Please list name

- ❑ Blood thinner ______________
- ❑ Antibiotic ______________
- ❑ High blood pressure medicine ______________
- ❑ High Cholesterol medicine ______________
- ❑ Acid Reflux medicine ______________
- ❑ Emotional Condition medicine ______________
- ❑ Insulin, or other diabetes drug ______________
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Pain killer ______________
- ❑ Weight loss Medicine ______________
- ❑ Osteoporosis (bone density) medicine/Bisphosphanates ______________
- ❑ Immunosuppressant ______________
- ❑ Contraceptive ______________
- ❑ Other ______________

Does patient have a medical Power of Attorney in effect?
❑ Yes ❑ No

Name of your physician ______________
Office Phone # ______________

Anything else you would like us to know: ______________

PATIENT INFORMATION

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Signature of patient (or guardian):

____

Date:____