# PATIENT INFORMATION FORM

Patient Name: First _____ MI_____ Last: _____

Nickname: _____

Address: Street _____

City _____ State/Zip code_____

Phone: Home _____ Mobile: _____

Email address _____

Social Security Number _____ Date of Birth _____

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**Is the patient a minor?** Yes or No (please circle)

Name of Responsible Party: First _____ Last_____

Date of Birth: _____ Relationship to patient: Self / Spouse / Parent / Other_____

Address: (if different from patient) Street_____ City_____

State/Zip code _____

Phone: Home _____ Mobile _____

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**Dental Benefit Plan Information**

Primary Dental Plan Name _____

Address: Street _____

City _____ State/Zip code_____

Phone Number _____

Name of Insured _____ Date of Birth _____

ID Number _____ Group Number _____

Name of Employer _____

Patient Relationship to Insured _____

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**Secondary Dental Plan Name**_____

Address: Street _____

City _____ State/Zip Code _____

Name of Insured _____ Date of Birth _____

ID Number _____ Group Number _____

Employer Name _____

Relationship to Insured _____

# PATIENT MEDICAL HISTORY

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

What are your main dental concerns? _____

**Do you have or have you had any of the following? Please circle Yes or No**

1. Y N Heart Disease
2. Y N Mitral Valve Prolapse
3. Y N Stroke
4. Y N Rheumatic Fever
5. Y N Pacemaker
6. Y N Stent
7. Y N Abnormal Blood Pressure
8. Y N Anemia
9. Y N Hay Fever
10. Y N Sinus Trouble
11. Y N Epilepsy/Seizures
12. Y N Ulcers
13. Y N Liver Disease
14. Y N Hepatitis Type____
15. Y N Diabetes
16. Y N I usually take antibiotics prior to dental treatment
17. Y N Have you ever taken Fen-Phen or Redux?

**Women:**

Y N Are you taking birth control medication?

Y N Are you or could you be pregnant or nursing?

**List any major surgeries:**

_____

_____

_____

18. Y N Kidney Disease
19. Y N Arthritis
20. Y N Tumor or Malignancy
21. Y N Cancer/Chemotherapy/Radiation
22. Y N Prolonged Bleeding Disorder
23. Y N Tuberculosis or Lung Disease
24. Y N Asthma
25. Y N Infectious Mononucleosis ("Mono")
26. Y N Herpes (Oral/Cold Sores)
27. Y N History of Drug Addiction
28. Y N HIV/AIDS
29. Y N Immune Suppressed Disorder
30. Y N Hearing Loss
31. Y N Fainting Spells
32. Y N Glaucoma
33. Y N Artificial Joints/Implants: _____
34. Y N I smoke or use chewing tobacco
    If yes, how much per day?_____ How many Years?_____
35. Y N Do you take or have you ever taken **Bisphosphonates** (Fosamax, Boniva, Actonel, Aredia, Zometa, etc...) for osteoporosis or any other condition?
36. Y N Are you taking **Blood Thinners?** (Plavix, Eliquis, Warfarin, Xarelto, Coumadin, Aspirin etc...)
37. Please list any other medical conditions or medical history **NOT** listed on this form

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**Are you allergic to any of the following?**

1. Y N **Aspirin**
2. Y N **Ibuprofen**
3. Y N **Sulfa Drugs/Sulfites/Sulfides**
4. Y N **Penicillin**
5. Y N **Codeine**
6. Y N **Latex, Metals, Plastics**
7. Y N **Local Anesthetics (i.e., Novocain, Lidocaine)**
8. Y N **Other** _____

**Please list all medications you are currently taking:**

**Medication**_____ **Condition:**_____
**Medication**_____ **Condition:**_____
**Medication**_____ **Condition:**_____
**Medication**_____ **Condition:**_____
**Medication**_____ **Condition:**_____
**Medication**_____ **Condition:**_____

**In case of emergency please contact:**

Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

**Initial medical/dental reviewed by:**

_____ Date_____
Doctors Signature

**Periodic medical/dental health reviewed by:**

_____ Date_____
Doctors Signature

_____ Date_____
Doctors Signature

_____ Date_____
Doctors Signature

_____ Date_____
Patient/Guardian Signature