PATIENT INFORMATION AND HEALTH HISTORY

PLEASE COMPLETE BOTH SIDES

1. Patient's Name: _____
Last First Middle Initial

2. Patient's Address: _____
Street

_____
City State Zip

3. Patient's Phone: _____
Home

_____ _____
Work Cell

4. Patient's Date of Birth: _____

5. Patient's Employer: _____
Name (Business name if self-employed)

_____
Street City Zip

6. Patient's Social Security No. _____

Occupation _____

Email Address _____

Driver's License _____

7. Check One: Married ❑ Unmarried ❑ Separated ❑ Widowed ❑

8. Spouse's Name: _____
Last First Middle Initial

9. Spouse's Address: (if different)_____
Street

_____
City State Zip

10. Spouse's Phone: _____ _____
Home Cell

11. Spouse's Date of Birth: _____

12. Spouse's Employer: _____
Name (Business name if self-employed)

_____
Street City Zip

13. Spouse's Social Security No._____

Spouse's Occupation _____

14. Referred to our office by Dr:

_____
Name

_____
Address

INSURANCE INFORMATION

Patients with insurance are responsible for payment of their bills. It is not always possible to predict which services are covered by the carrier or how much they will pay for a particular service. We will assist you in every way possible with your insurance carrier.

DENTAL INSURANCE

Primary

Employee's Name: _____

Employee's Social Security No. _____/_____/_____

Check One: Male ❑ Female ❑

Insurance Company Name: _____

Group Plan No. _____

Local Union No. _____

Policy or Account No. _____

Employer: _____
Name (Business name if self-employed)

_____
Street City Zip

Secondary

Employee's Name: _____

Employee's Social Security No. _____/_____/_____

Check One: Male ❑ Female ❑

Insurance Company Name: _____

Group Plan No. _____

Local Union No. _____

Policy or Account No. _____

Employer: _____
Name (Business name if self-employed)

_____
Street City Zip

If this treatment will be covered by medical insurance due to an ongoing claim, please give information to front desk.

PLEASE TURN OVER

Answers to the following questions are for our records only and will be considered confidential.

1. Date of Last Physical Examination _____ Physician's Name _____

_____ Physician's Telephone # _____

2. Date of Last Dental Examination _____ Dentist's Name _____

	YES	NO	
3.	☐	☐	Are you presently under physician's care? Explain: _____
4.	☐	☐	Are you pregnant? Est. date of delivery _____
5.	☐	☐	Any past serious illnesses or operations? Explain: _____
6.	☐	☐	Are you taking any drugs, medicines or injections? If so, which ones _____
			_____
7.	☐	☐	Have you ever taken Fen-Phen, Pondimin *(Fenfluramine)* or Redux with Phentermine? _____
8.	☐	☐	Do you have allergies? *Allergic to any medication?* Explain: _____
9.	☐	☐	Do you have any allergy to latex or latex products? _____
10.	☐	☐	Do you have any blood disorder, any bleeding tendency or bruise easily? _____
11.	☐	☐	Do you have anemia? _____
12.	☐	☐	Do you have a prosthetic joint or implant? _____
13.	☐	☐	Have you ever had any cardiovascular disease? *Heart trouble, heart attack, rheumatic fever, mitral valve prolapse,coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, heart valve problem* _____
14.	☐	☐	Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel®, Fosamax®, or similar medication within the past twelve years? _____
15.	☐	☐	Have you ever been told by your physician that you need to be premedicated? _____
16.	☐	☐	Have you ever had high blood pressure? _____
17.	☐	☐	Have you ever had any liver disease? *Hepatitis? Jaundice?* _____
18.	☐	☐	Do you have diabetes? _____
19.	☐	☐	Have you ever had tuberculosis? _____
20.	☐	☐	Do you have asthma, emphysema or any lung disorders? _____
21.	☐	☐	Have you ever had radiation treatment or surgery for a tumor, growth, or other condition? _____
			_____
22.	☐	☐	Have you ever had any serious trouble associated with previous dental treatment? _____
23.	☐	☐	Do you have glaucoma? _____
24.	☐	☐	Have you ever had epilepsy, fainting spells, seizures? _____
25.	☐	☐	Have you ever tested Positive for the HIV virus? _____
26.	☐	☐	Do you have kidney disease or problem? _____
27.	☐	☐	Do you have an ulcer or other stomach or intestinal problem? _____
28.	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about? _____
			_____

This information is true and correct to the best of my knowledge.

A copy of this office's NOTICE OF PRIVACY PRACTICES and the DENTAL MATERIALS fact sheet has been made available to me.

Signature: _____ Date: _____

Doctor's Initial _____