Patient Information Form

Date_____

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

Patient Social Security #_____ **Email** _____

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#**_____**Birthdate**_____

Secondary Dental Insurance_____ **Group #**_____

Insured's Name_____**SS#/ID#**_____**Birthdate**_____

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
❑ Auricular Cochlear 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 antibiotic 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 bisphosphonate 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. Do you have ***ALLERGIES*** to the following? □ Local Anesthetic □ Latex Products □ Iodine
□ Antibiotic_____ □ Aspirin or NSAIDs □ Codeine or other narcotics □ Other _____

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