

**Patient Information Form**



Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Social Security # \_\_\_\_\_

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# \_\_\_\_\_ Birth date \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_ SS#/ID# \_\_\_\_\_ Birth date \_\_\_\_\_

**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:
 

<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cardiac Pacemaker	<input type="checkbox"/> Taking Blood Thinners	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Auriculocochlear Implant	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Allergies	<input type="checkbox"/> STDs
<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> 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 biphosphonate 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. Have you ever had an **ALLERGIC** reaction to the following?  
 Penicillin or other antibiotic  Aspirin or NSAIDs  Local Anesthetic  Latex Products  
 Iodine  Codeine or other narcotics

12. (Females only) Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No