Today's Date _____

# PATIENT INFORMATION SHEET

Patient First Name: _____ M.I. ____ Last Name: _____ ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Ph. # (no dashes) : _____ Cell # (no dashes) : _____ Wk # (no dashes) : _____ Ext.: _____

Birthdate: (MMDDYYYY) (no slashes) : _____ Social Security Number (no dashes) : _____

Emergency Contact Name: _____ Ph. # (no dashes) : _____ Cell #: (no dashes) : _____

## PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT:

First Name : _____ M.I. ____ Last Name: _____ Relationship : _____

Address: (if different) _____ City: _____ State: _____ Zip Code: _____

Birthdate: (MMDDYYYY) (no slashes) : _____ Social Security Number (no dashes) : _____

Ph. # (no dashes) : _____ Cell # (no dashes) : _____ Wk # (no dashes) : _____ Ext.: _____

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

## PRIMARY INSURANCE POLICY HOLDER:

First Name : _____ M.I. ____ Last Name: _____ Relationship to patient : _____

Birthdate: (MMDDYYYY) (no slashes) : _____ Social Security Number (no dashes) : _____

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

Group/Policy#: _____ Insurance Company: _____

## SECONDARY INSURANCE POLICY HOLDER:

First Name: _____ M.I. ____ Last Name: _____ Relationship to patient: _____

Birthdate: (MMDDYYYY) (no slashes) : _____ Social Security Number (no dashes) : _____

Employer Name: _____ Employer Address: _____

Employer City: _____ State: _____ Zip Code: _____

Group/Policy# _____ Insurance Company: _____

# MEDICAL HISTORY

Patient First Name: _____ M.I. ____ Last Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now ? ☐ No ☐ Yes

Have you ever been hospitalized or had a major operation ? ☐ No ☐ Yes Explain: _____

Have you ever had a serious head or neck injury ? ☐ No ☐ Yes Explain: _____

Are you taking any medications, pills, or drugs ? ☐ No ☐ Yes Explain: _____

Do you take, or have taken, Phen-Fen or Redux ? ☐ No ☐ Yes

Do you use tobacco ? ☐ No ☐ Yes

Do you use controlled substances ? ☐ No ☐ Yes

Women: Are you ☐ Pregnant / Trying to get pregnant? ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal

☐ Latex ☐ Local Anesthetics ☐ Other _____

**Do you have, or have you had, any of the following?**

*** Conditions may require medication** **N/A - Not answered by patient**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Irregular Heartbeats | ☐ Scarlet Fever |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Gential Herpes | ☐ Kidney Problems | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Congential Heart Disorder | ☐ Glaucoma | ☐ Leukemia | ☐ Sickle Cell Disease |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Liver Disease | ☐ Sinus Trouble |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Low Blood Pressure | ☐ Spinal Bifida |
| ☐ Arthritis / Gout | ☐ Diabetes | ☐ Heart Murmur * | ☐ Lung Disease | ☐ Stomach/Intestinal Disease |
| ☐ Artificial Heart Valve * | ☐ Drug Addiction | ☐ Heart Pace Maker * | ☐ Mitral Valve Disease * | ☐ Stroke |
| ☐ Artificial Joint * | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Psychiatric Care | ☐ Tonsillitis |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Radiation Treatments | ☐ Tuberculosis |
| ☐ Breathing Problems | ☐ Excessive Thrist | ☐ Herpes | ☐ Recent Weight Loss | ☐ Tumors or Growths |
| ☐ Bruise Easily | ☐ Fainting Spells/Diziness | ☐ High Blood Pressure | ☐ Renal Dialysis | ☐ Ulcers |
| ☐ Cancer | ☐ Frequent Cough | ☐ Hives or Rash | ☐ Rheumatic Fever * | ☐ Venereal Disease |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hypoglycemia | ☐ Rheumatism | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ No ☐ Yes _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: _____ Date: _____

Print Form Reset Form