Patient Information

Date :_____

Please note that it is important to fill in all the fields. Thank you.

*Name : (Order : First-Mid-Last) _____ _____ _____ *Birthday : __/___/____

*Patient address : _____ City :_____ State :_____ Zip :_____ APT# :_____

Telephone : *Home :(___) - ___ - ____ Work :(___) - ___ - ____ Ext:____ Cell :(___) - ___ - ____

*Email address : _____ Social Security Number :____-____-____

How did you hear about us? _____ Have you visited our website? Yes ☐ No ☐

Referred by : _____ Occupation : _____

Primary insurance carrier : _____

Group number : _____

Employer : _____

Employee : (If different from patient) _____

Insurance ID # : _____

Birthday : __/___/____

Address : (If different from above) _____

City :_____

State : _____ Zip :_____ APT# : _____

Secondary insurance carrier : _____

Group number : _____

Employer : _____

Employee : (If different from patient) _____

Insurance ID # : _____

Birthday : __/___/____

Address : (If different from above) _____

City :_____

State : _____ Zip :_____ APT# : _____

Primary physician :_____ Phone :(___) - ___ - ____

If you have any allergies or have ever had an allergic reaction to any medications, substances, or materials (including latex or penicillin) please tell us about it (be sure to include drugs and medication as well).

Have you ever taken the diet drugs Fhen-Fen or Redux? Yes ☐ No ☐

Have you taken cortisone medication within the last 2 years? Yes ☐ No ☐

Have you ever been advised to take any antibiotics or other medication prior to dental appointments? Yes ☐ No ☐

Is there anything else that you want us to know about your health?

Date & Time : _____

Health History

01. Is your general health good? Yes ☐ No ☐
02. Has there been a change in your health within the last year? Yes ☐ No ☐
03. Have you been hospitalized or had a serious illness in the last three years? Yes ☐ No ☐

If yes, why? _____

04. Are you being treated by a physician now? Yes ☐ No ☐ For what? _____

Date of last medical exam? _____ Date of last dental exam? _____

05. Have you had problems with prior dental treatment? Yes ☐ No ☐
06. Are you in pain now? Yes ☐ No ☐

II. Have you experienced :

Yes/No		Yes/No		Yes/No	
07. ☐ ☐	Chest pain (angina)?	15. ☐ ☐	Diarrhea, constipation, blood in stools?	22. ☐ ☐	Fainting spells?
08. ☐ ☐	Swollen ankles?	16. ☐ ☐	Frequent vomiting, nausea?	23. ☐ ☐	Blurred vision?
09. ☐ ☐	Shortness of breath?	17. ☐ ☐	Difficulty urinating blood in urine?	24. ☐ ☐	Seizures?
10. ☐ ☐	Recent weight loss, fever, night sweats?	18. ☐ ☐	Dizziness?	25. ☐ ☐	Excessive thirst?
11. ☐ ☐	Persistent cough, coughing up blood?	19. ☐ ☐	Ringing in ears?	26. ☐ ☐	Frequent urination?
12. ☐ ☐	Bleeding problems, bruising easily?	20. ☐ ☐	Headaches / Neck or back pain?	27. ☐ ☐	Dry mouth?
13. ☐ ☐	Sinus problems?	21. ☐ ☐	Joint pain, stiffness?	28. ☐ ☐	Jaundice?
14. ☐ ☐	Difficulty swallowing?				

III. Do you have or have you had :

Yes/No		Yes/No		Yes/No	
29. ☐ ☐	Heart disease?	37. ☐ ☐	Stomach problems, ulcers?	44. ☐ ☐	Skin diseases?
30. ☐ ☐	Heat attack, heart defects?	38. ☐ ☐	Allergies to: drugs, foods, medications, latex?	45. ☐ ☐	Anemia?
31. ☐ ☐	Heart murmurs?	39. ☐ ☐	Family history of diabetes, heart problems, tumors?	46. ☐ ☐	VD (syphilis or gonorrhea)?
32. ☐ ☐	Rheumatic fever?	40. ☐ ☐	AIDS / HIV positive?	47. ☐ ☐	Herpes?
33. ☐ ☐	Stroke, hardening of arteries?	41. ☐ ☐	Tumors, cancer?	48. ☐ ☐	Kidney, bladder disease?
34. ☐ ☐	High or Low blood pressure?	42. ☐ ☐	Arthritis, rheumatism?	49. ☐ ☐	Thyroid, adrenal disease?
35. ☐ ☐	Asthma, TB, emphysema, other lung diseases?	43. ☐ ☐	Eye diseases/Glaucoma?	50. ☐ ☐	Diabetes / Hypoglycemia?
36. ☐ ☐	Hepatitis, other liver disease?				

IV. Do you have or have you had :

Yes/No		Yes/No		Yes/No	
51. ☐ ☐	Psychiatric care?	55. ☐ ☐	Artificial joint?	58. ☐ ☐	Surgeries?
52. ☐ ☐	Radiation treatments?	56. ☐ ☐	Hospitalization?	59. ☐ ☐	Pacemaker?
53. ☐ ☐	Chemotherapy?	57. ☐ ☐	Blood transfusions?	60. ☐ ☐	Contact lenses?
54. ☐ ☐	Prosthetic heart valve?				

V. Are you taking :

61. Yes ☐ No ☐ Recreational drugs? 62. Yes ☐ No ☐ Tobacco in any form?
63. Yes ☐ No ☐ Alcohol? 64. Yes ☐ No ☐ Bisphosphonates (Fosamax)?
65. Yes ☐ No ☐ Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?

Please list : _____

VI. Women only :

65. Yes ☐ No ☐ Are you or could you be pregnant or nursing? 66. Yes ☐ No ☐ Taking birth control pills?

VII. All patients :

67. Yes ☐ No ☐ Do you snore on a regular basis?
68. Yes ☐ No ☐ Do you have hypertension or a history of cardiovascular disease?
69. Yes ☐ No ☐ Do you ever feel sleepy during the day or fall asleep in inappropriate situations?

If the answer is "Yes" to any of the above, please complete the Berlin and Epworth Sleepiness Scale questionnaires.

80. Yes ☐ No ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain : _____

☐ *I agree and to the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and / or medication.

*Patient's signature : _____ Date : _____

Your digital signature (full name) is as legally binding as a physical signature.

Recall Review:

Parient's signature: _____ Reviewed by: _____ Date: _____

Parient's signature: _____ Reviewed by: _____ Date: _____

Parient's signature: _____ Reviewed by: _____ Date: _____

Date & Time : _____