WELCOME!

We are please to welcome you to our family practice. Please take a few minutes to fill out these forms completely. If you have any questions we will be glad to help you. We look forward to working with you and maintaining your dental health.

PATIENT

Patient's name: first / middle / last

Social Security Number

Patient's address: street / city / state / zip

Patient's home phone

Patient's email address

Patient's cell phone

How did you hear about us? ○ Patient Referral (Please put their name above, so we may thank them) ○ Our website

Patient's date of birth

Employer Name - Yes your dental insurance through this company ○ No ○ Yes

How long have you been employed

Business address: street / city / state / zip

Business phone number

PERSON RESPONSIBLE FOR ACCOUNT *(OTHER THAN PATIENT)*

Name: first / middle / last

Social Security Number

Address: street / city / state / zip

Relationship to patient

Email address

Cell phone number

Home phone number

Employer Name - Yes your dental insurance through this company ○ No ○ Yes

How long have you been employed

Business address: street / city / state / zip

Business phone number

NAME OF DENTAL INSURANCE COMPANY

Company name

Subscriber ID number

Subscribers name

Date of birth of subscriber

SPOUSE

Name of spouse

Cell Phone

EMERGENCY CONTACT

Name:

Cell phone number

Home phone number

PATIENT MEDICIAL HISTORY

Your Primary Physician's Name _____ Phone Number _____

Pharmacy Name and Location _____ Phone Number _____

A) Please check no or yes to the following conditions:

Yes	No	Conditions:
○	○	Acid Reflux
○	○	Alcohol, Chemical and/or Drug Abuse
○	○	Anemia
○	○	Angina Pectoris
○	○	Arteriosclerosis
○	○	Arthritis
○	○	Artificial Bones
○	○	Artificial Heart Valve
○	○	Asthma
○	○	Autoimmune Disorder
○	○	Bleeding/Bruise Easily
○	○	Blood Pressure High or Low (Circle)
○	○	Blood Transfusion
○	○	COPD
○	○	Cancer, Chemo/Radiation Therapy
○	○	Colitis
○	○	Congenital Heart Defect

Yes	No	Conditions:
○	○	Depression
○	○	Diabetes
○	○	Difficulty in Breathing
○	○	Difficulty in Sleeping
○	○	Emphysema
○	○	Epilepsy
○	○	Fainting Spells
○	○	Fever Blisters
○	○	Frequent Headaches
○	○	Glaucoma
○	○	Heart Attack
○	○	Heart Surgery
○	○	Hemophilia
○	○	Hepatitis A, B, or C (Circle)
○	○	Immune System Disorders
○	○	Kidney Problems
○	○	Liver Disease

Yes	No	Conditions:
○	○	Meniere's Disease
○	○	Mitral Valve Prolapse
○	○	Nasal Allergies
○	○	Osteoporosis
○	○	Pacemaker
○	○	Pneumocystitis
○	○	Psychiatric Problems
○	○	Rheumatic Fever
○	○	Seizures
○	○	Sickle Cell Disease
○	○	Stroke
○	○	Thyroid Problems
○	○	Tuberculosis
○	○	Ulcers
○	○	Venereal Disease
○	○	Yellow Jaundice

Do you smoke or use tobacco? ○ No ○ Yes

Do you have any other conditions, diseases, or surgeries? ○ No ○ Yes

Please list: _____

_____

_____

If female, please answer the following questions: Are you taking birth control pills? ○ No ○ Yes Are you pregnant? ○ No ○ Yes Are you nursing? ○ No ○ Yes

If yes, # of weeks: _____

B) Please check no or yes to the following allergies:

Yes	No	Allergies:
○	○	Aspirin
○	○	Codeine
○	○	Dental Anesthetics
○	○	Erythromycin
○	○	Jewelry

Yes	No	Allergies:
○	○	Latex
○	○	Metals
○	○	Asthma
○	○	Penicillin
○	○	Tetrcycline

Other Allergies: _____

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_____

_____

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C) Please list all current prescribed and over the counter medications along with dosages.

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_____

_____

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_____

Patient Signature _____ Date _____