

PATIENT INFORMATION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME # \_\_\_\_\_

WORK # \_\_\_\_\_

SOC. SEC# \_\_\_\_\_ D.O.B. \_\_\_\_\_ CELL # \_\_\_\_\_

BUSINESS: \_\_\_\_\_

REFERRING DENTIST \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ TELEPHONE \_\_\_\_\_

- |  |  |   |  |
|--|--|---|--|
| Do you or have you ever had?                       | Check One:   | Do you or have you ever had?                      | Check One:   |
| 1. Diabetes  | Yes <input type="checkbox"/> No <input type="checkbox"/> | 9. Allergic to Penicillin                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Anemia  | Yes <input type="checkbox"/> No <input type="checkbox"/> | 10. Other medication allergies, please list _____ |  |
| 3. Kidney Disease                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |
| 4. Hepatitis A, B, or C or any other Liver Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | 11. Allergic to latex                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. T.B. or Thyroid Disease                         | Yes <input type="checkbox"/> No <input type="checkbox"/> | 12. Taking birth control pills or hormones        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Are you on a blood thinner, which one _____     | Yes <input type="checkbox"/> No <input type="checkbox"/> | 13. Are you pregnant                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Were you advised to stop this prior to dental work | Yes <input type="checkbox"/> No <input type="checkbox"/> | 14. Joint Replacement                             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. History of Heart Disease                        | Yes <input type="checkbox"/> No <input type="checkbox"/> | If so, when _____                                 |  |
| Angina, Stents, Valve Replacement, etc.            |  | 15. Do you premedicate                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. High Blood Pressure                             | Yes <input type="checkbox"/> No <input type="checkbox"/> | 16. Exposure to the HIV virus                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Cancer  | Yes <input type="checkbox"/> No <input type="checkbox"/> | 17. Recent exposure to Covid 19                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |

ADDITIONAL MEDICAL ISSUES \_\_\_\_\_

LIST MEDICATIONS \_\_\_\_\_

\* PLEASE BRING YOUR DENTAL INSURANCE CARD AT THE TIME OF APPOINTMENT \*

Person Responsible for Account - Check one:  Patient  Father (Husband)  Mother (Wife)  Guardian

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PRIMARY DENTAL INSURANCE CO. \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

GROUP # \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SECONDARY DENTAL INSURANCE CO. \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

GROUP # \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_ Date \_\_\_\_\_