

PATIENT INFORMATION

NAME _____
STREET ADDRESS _____
CITY, STATE, ZIP CODE _____
CELL# _____ WORK# _____
EMAIL ADDRESS _____
SOC. SEC# _____ D.O.B. _____
REFERRING DENTIST _____ TELEPHONE _____
PHYSICIAN _____ TELEPHONE _____

Do you or have you ever had?

- | | |
|--|--|
| 1. Diabetes | Yes ☐ No ☐ |
| 2. Anemia | Yes ☐ No ☐ |
| 3. Kidney Disease | Yes ☐ No ☐ |
| 4. Hepatitis A, B, or C or any Liver Disease | Yes ☐ No ☐ |
| 5. T.B. or thyroid disease | Yes ☐ No ☐ |
| 6. Are you on a blood thinner? | Yes ☐ No ☐ |
| Which one _____ | |
| Were you advised to stop blood thinner? | Yes ☐ No ☐ |
| 7. History of Heart Disease | Yes ☐ No ☐ |
| Angina, Stents, Valve Replacement, etc. | |
| 8. High Blood Pressure | Yes ☐ No ☐ |
| 9. Cancer | Yes ☐ No ☐ |

Check One:

Do you or have you ever had?

Check One:

- | | |
|---|--|
| 9. Allergic to Penicillin | Yes ☐ No ☐ |
| 10. Other medication allergies , please list | |
| _____ | |
| 11. Allergic to latex | Yes ☐ No ☐ |
| 12. Taking birth control pills or hormones | Yes ☐ No ☐ |
| 13. Are you pregnant | Yes ☐ No ☐ |
| 14. Joint Replacement | Yes ☐ No ☐ |
| If so, when _____ | |
| 15. Do you premedicate | Yes ☐ No ☐ |
| 16. Exposure to the HIV virus | Yes ☐ No ☐ |
| 17. Recent exposure to Covid 19 | Yes ☐ No ☐ |

ADDITIONAL MEDICAL ISSUES

LIST MEDICATIONS

* DENTAL INSURANCE INFORMATION *

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

NAME _____

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# _____ GROUP. # _____

RELATIONSHIP TO PATIENT _____

SIGNATURE OF RESPONSIBLE PARTY _____ Date _____