Patient Information

Date: ______________________

Referred by: ____

Patient Name: ____
Residence: Street: ____
City: ________________________ State: _____ Zip: ____________

Home Phone: _______________ Work: _______________ Cell: ____________

Patient Date of Birth: ___________ Social Security#: _________________________
Employment: Self: ____
Spouse: ____

Person to notify in case of emergency:
Name: ___________________________ Telephone: ________________________
Person responsible for account: ____

Dental Insurance? Yes / No (circle one)
Name and address of insurance company

____
Policy or ID Number: _____________________________ Group: ________________
Name of Insured: _________________________ Insured Date of Birth: ___________
Secondary Insurance Company: ____

Have you or any member of your family been in this office before? Yes / No (circle one)

Medical History (Circle one for each category)

Do you, or have you ever had:

Anemia?	Yes	No
Diabetes?	Yes	No
Rheumatic fever?	Yes	No
Liver Disease?	Yes	No
Hepatitis?	Yes	No
Tuberculosis?	Yes	No
Ulcers?	Yes	No
Thyroid disease?	Yes	No
Kidney disease?	Yes	No
Heart disease? (specify) (high blood pressure, angina, heart attack, etc.) ____________ ___________________________	Yes	No
Are you HIV positive?	Yes	No
Stomach Ailments?	Yes	No
Do you take blood thinners?	Yes	No
Are you a bleeder?	Yes	No
Are you pregnant?	Yes	No
Do you take hormone or birth control pills?	Yes	No
Allergic to penicillin?	Yes	No
Other Allergies? ______________________________	Yes	No
Are you under the care of physician now?	Yes	No

Do you routinely take antibiotics before dental appointments? Yes No
Medications currently taken: ____
Do you have any other medical condition or disease? ____________________________

Signature: ____ Date: ____________