PATIENT INFORMATION AND HEALTH HISTORY

We are complimented that you have selected us to provide dental care for you and your family.
So that we can serve you better, please complete both sides of this new patient information and health history form.

PERSONAL INFORMATION

PATIENT NAME _____ SS# _____ DATE OF BIRTH _____

IF CHILD, RESPONSIBLE PARTY NAME _____

ADDRESS _____ PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ OWN/RENT _____ HOW LONG? ____

CELL PHONE ( ) _____ E-MAIL ADDRESS _____

PATIENT/PARENT EMPLOYED BY _____ PHONE ( ) _____

BUSINESS ADDRESS _____ ZIP _____

PRESENT POSITION _____ HOW LONG? _____

IF PATIENT IS STUDENT, NAME OF SCHOOL _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES YES _____ NO _____

IF SO, NAME OF COMPANY _____

IS INS. POLICY CONNECTED WITH YOUR UNION YES _____ NO _____ NAME OF UNION _____

UNION LOCAL NO. _____ GROUP/POLICY NO. _____ INSURED SS# _____

INSURED DATE OF BIRTH _____

SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____

NAME OF SPOUSE _____ SPOUSE SS# _____

SPOUSE'S EMPLOYER _____ PHONE ( ) _____

BUSINESS ADDRESS _____ ZIP _____

DOES SPOUSE HAVE INSURANCE? YES _____ NO _____ NAME OF COMPANY _____

SPOUSE DATE OF BIRTH _____ GROUP/POLICY # _____ UNION _____ YES _____ NO _____

UNION NAME _____ UNION LOCAL # _____

NEAREST RELATIVE _____ ADDRESS _____

HOW WERE YOU REFERRED TO OUR PRACTICE? _____

WHAT METHOD OF PAYMENT WILL YOU BE USING TODAY? CHECK ( ) CASH ( ) CREDIT(( )

MEDICAL INFORMATION

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE

(Your responses are totally confidential)

Anemia
Diabetes (Date of onset: _____)
Epilepsy or Seizures
(Last occurrence: _____)
Arthritis or Osteoporosis
Hepatitis (When: _____)
Fever Blisters or Cold Sores
Cortisone Medicine
Drug Problems
Hemophilia
Sinus Trouble or Asthma
Fungal; Infections
Kidney Problems
Urinary Infections
Bulimia or Anorexia

Use of Cocaine (affects
dental anesthetic)
Rheumatic Fever
Stroke or Angina (When: _____)
Heart Murmur
Congenital Heat Lesions
Abnormal Heart Condition
High (or low) Blood Pressure
(S _____ /D _____)
Abnormal or Prolonged
Bleeding From a Cut
Herpes (1) or (2)
Psychiatric Treatment
Mononucleosis
AIDS/ARC

HIV Positive
Epstein-Barr Virus (EBV)
Gonorrhea or Syphilis
Tuberculosis (TB)
Fainting Spells
Blood Transfusions
White Patches in the Mouth
ALLERGIES:
Tetracycline
Penicillin or Erythromycin
Local Anesthetic
Aspirin/Valium/Pollen
Other Medication or Drugs
Women: Are you pregnant?

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