Patient Information Record

This information is for our records only

Name _____

Age _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Telephone Number - Home _____

Marital Status _____ Spouse's name _____

Referred by _____

Physician _____

PATIENT OR PERSON RESPONSIBLE FOR PAYMENT

Name _____

Relationship _____

Occupation _____

SS Number _____

Employer _____

Address _____

City _____ State _____ Zip _____

Telephone Number - Work _____

DENTAL INSURANCE INFORMATION

Company _____

Policy Number _____

Group Number _____

Patient Signature _____
(If a minor, name of parent or guardian)

Date _____

Reviewed _____

Medical History

1. Are you in good health? Yes _____ No _____

2. Have you been under the care of a physician during the past three years? Yes _____ No _____
If yes, for what? _____

3. Do you take any medications, drugs, pills or inhalants? Yes _____ No _____
If yes, list them (including Phen-Fen) _____

4. Have you been in the hospital or had any operations? Yes _____ No _____
If yes, for what? _____

5. How much do you smoke? _____
How much do you drink: _____

6. Do you use recreational drugs: Yes _____ No _____

7. Have you now, or ever had any of the following? Check where applicable.

	Yes	No		Yes	No
Heart trouble	☐	☐	Emphysema	☐	☐
High blood pressure	☐	☐	Chronic cough	☐	☐
Heart murmur	☐	☐	Asthma	☐	☐
Stroke	☐	☐	Bronchitis	☐	☐
Rheumatic fever	☐	☐	Anemia	☐	☐
Angina/chest pain	☐	☐	Bleeding problems	☐	☐
Heart Attack	☐	☐	Kidney disease	☐	☐
Sinus trouble	☐	☐	Diabetes	☐	☐
Tuberculosis	☐	☐	Drug/alcohol problems	☐	☐
HIV infection	☐	☐	Anesthetic reactions	☐	☐
Arthritis	☐	☐	Epilepsy	☐	☐
Seizure	☐	☐	Thyroid problems	☐	☐
Cancer	☐	☐	Ulcers/bowel problems	☐	☐
Glaucoma	☐	☐	Jaundice	☐	☐
Veneral disease	☐	☐	Hepatitis	☐	☐
TMJ	☐	☐	if so A☐ B☐ C☐		

8. A. Are you allergic to any medicines such as penicillin, codeine, aspirin or novocaine? Yes _____ No _____
Which one? _____
B. Do you have Latex allergy? Yes _____ No _____

9. Is it possible you are pregnant or nursing a baby? Yes _____ No _____

10. Do you wear contact lenses? Yes _____ No _____