PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health and is required to verify your dental coverage.

Please fill out this form in it's entirety. All information below is required to register you as a patient of the practice. All the info provided will be kept completely confidential in accordance to HIPAA Laws

Patient's name* _____ **Birth Date*** _____ **SSN *** _____

Cell Phone* _____ Alternate Phone _____ **Email*** _____

Mailing address* _____Apt/Suite_____ City _____State _____ Zip _____

How did you hear about our office?*❑ GOOGLE ❑ RELATIVE ❑ FRIEND ❑ ZOCDOC ❑ YELP ❑ FACEBOOK

FRIEND/RELATIVE WE CAN THANK FOR REFERRING YOU_____

INSURANCE INFORMATION*: **❑I am not using dental insurance for my visit**

❑ I AUTHORIZE THE OFFICE TO BILL MY INSURANCE

Dental Insurance Carrier_____ Insurance ID_____ Primary Subscriber _____ DOB_____

PHARMACY INFORMATION* All RX information is sent to your pharmacy electronically. Please provide details below:

Pharmacy Name _____ Pharmacy Location _____ Pharmacy Phone # _____

MEDICAL HEALTH HISTORY*

Do you have or have you had any of the following?
(Please check any that apply. **If none apply leave blank**)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma Asthma
- ❑ OTHER _____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Last time your dental xrays taken*:_____**Last dental cleaning*** _____**What was your last dental treatment for**:*_____

Would you like your teeth whiter?_____**Are you happy with your smile**?_____ **If no, please explain**

_____

PLEASE WRITE THE MAIN REASON FOR YOUR VISIT TODAY*: _____

Signature of patient (or guardian) _____ Date _____