MARTY CLOIN, DDS, R.PH
ARLINGTON, TX FAMILY DENTIST

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Age: _____

Home Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Alt phone: _____

Email: _____ How did you hear about our office? _____

Employer or School Attending: _____ Phone: _____

Occupation or Course of Study: _____ Favorite Hobby: _____

Emergency Contact Name: _____ Date of Birth: _____

Phone: _____ Relationship to patient: _____

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING

Name of Father: _____ Phone: _____

Name of Mother: _____ Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN SELF OR PARENT

Name: _____ Relationship to patient: _____

Address: _____City, State, Zip: __ _____ Ph: _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____

Social Security #_____Driver's License #: _____ Employer: _____

Insurance Company: _____ Group #: _____ Insurance Phone: _____

MEDICAL HISTORY

Are you currently under a physician's care? □ Yes □ No If yes, for what purpose: _____

Physician name: _____ Phone: _____ Date of last physical examination: _____

Are you taking any medication (RX or OTC)? □Yes □ No Are you taking a Biophosphonate (bone medication) now? □Yes □ No

List all medications, prescription and over the counter: _____

_____

Have you had/Do you have:

Abnormal Blood Pressure	□ Yes □ No	Heart Attack	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Asthma	□ Yes □ No	Heart Disease/Murmur	□ Yes □ No	Sinus Trouble/Hay Fever	□ Yes □ No
Cancer: _____	□ Yes □ No	Hepatitis	□ Yes □ No	Stroke	□ Yes □ No
Diabetes	□ Yes □ No	Jaundice/Liver Disease	□ Yes □ No	Tuberculosis/Lung Disease	□ Yes □ No
Epilepsy	□ Yes □ No	**Joint replacement**	□ Yes □ No	Ulcers	□ Yes □ No
Glaucoma	□ Yes □ No	Type: _____ When:_____		Are you pregnant?	□ Yes □ No

Do you have a family history of oral/throat cancer? □Yes □ No If so, whom? _____

Have you been hospitalized in the past 2 years: □Yes □ No If yes, for what purpose: _____

Have you ever been treated for venereal diseases- syphilis, gonorrhea, herpes, etc.? □ Yes □ No If so, when? _____

Have you ever been tested for HIV infections? □Yes □ No If so, when? _____ Are you HIV positive? □Yes □ No

Have you ever been treated for alcohol or drug dependency? □Yes □ No If so, when? _____

Are you allergic to: □Latex □Penicillin □Codeine □Local Injected Anesthetics □Iodine □Other Medications □I have no known allergies

Is there any other information we should know about the patient's health or previous dental visits? _____

_____ _____ _____

Signature of Patient or Guardian Date Signature of Dentist