Trinity Dental
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Phone: 260-582-2607
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PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name_______________________________/Preferred name___________________________

Date of Birth_______________Age_____ Sex ______ Married/Single/Widow/Divorced_______________

Home Address____________________City_____________________State_______Zip_____________

Billing Address____________________City_____________________State_______Zip_____________

Home Phone____________________________Cell___________________________Text Y N

E-mail____

Preferred Contact Method Home Phone Cell Phone Text Work E-mail Mail

Do not call Home Phone Cell Phone Text Work E-mail Mail

If Adult Driver's license#_____________________State______SS# of Patient_____________________

Parent if minor or Spouses Name____

Employer/Occupation______________________________Bus Phone___________________________

Emergency Phone# (other than spouse)____

Primary dental insurance_____________________Group#____________ID#____________________

Secondary dental insurance____________________Group#____________ID#___________________

Subscriber's name____________________________DOB________SS#_________________________

Name of previous Dentist________________________Date of last visit________________________

Have you been out the United States in the last 21 days. Yes No

Referred to us by____

See Notes____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following

Heart Problems

Chest pain	Y	N
Blood pressure problem	Y	N
Shortness of breath	Y	N
Heart murmur	Y	N
Heart valve problem	Y	N
Artificial heart valve	Y	N
Rheumatic fever	Y	N
Pacemaker	Y	N

Blood Problems

Easy bruising	Y	N
Frequent nosebleeds	Y	N
Abnormal bleeding	Y	N
Blood disease (anemia)	Y	N
Ever require a blood transfusion?	Y	N

Allergy Problems

Sinus problems	Y	N
Skin rashes	Y	N
Asthma	Y	N
Intestinal Problems	Y	N
Ulcers	Y	N
Weight gain or loss	Y	N
Special diet	Y	N
Kidney or bladder problems	Y	N

Do you need Premedication

required by physician (Antibiotic) Y N

Physician Name_______________________________

Physician Phone _______________________________

Diabetes	Y	N
Family history of diabetes	Y	N
Thirsty or mouth is dry much of the time	Y	N
Tuberculosis or other respiratory disease	Y	N
Persistent cough or swollen glands	Y	N
Do you drink alcohol?	Y	N

If so how much?_______________________________

Do you smoke?	Y	N

If so, how much?_______________________________

Hepatitis, jaundice, or liver trouble	Y	N
Herpes or other STD	Y	N
HIV-positive/AIDS	Y	N
Glaucoma	Y	N
Cancer/Tumor	Y	N
History of head injury?	Y	N
Epilepsy or other neurological disease?	Y	N
History of alcohol or drug abuse?	Y	N
Fainting spells, seizures or Epilepsy	Y	N
Frequent or severe headaches	Y	N
Thyroid Problems	Y	N

Bone or Joint Problems

Arthritis	Y	N
Back or neck pain	Y	N

Women

Are you Pregnant? DueDate_______________________	Y	N
Are you nursing?	Y	N

LIST ALL MEDICATIONS YOU ARE TAKING OR HAVE TAKEN IN THE LAST 12 MONTHS

DO YOU HAVE ANY DISEASE CONDITION OR PROBLEMS NOT LISTED PREVIOUSLY THAT YOU FEEL WE SHOULD KNOW ABOUT?

ARE YOU **ALLERGIC** TO ANY MEDICATIONS OR HAVE YOU REACTED ADVERSELY TO **ANY MEDICATION?**

DENTIST NOTES

Patient/Parent Signature____________________ **Date**____________

Dentist Signature____________________ **Date**____________