by Dr. Santos LLC

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ADULT PATIENT INFORMATION

Date ______________________

How were you referred to our practice? ☐ Valpak ☐ Postcard ☐ TV Commercial ☐ Internet ☐ Other ______________________

Patient's Name ______________________
First Middle Last

Home Address ______________________
Street City State Zip

Driver's License # ______________________

Home Phone # ______________ Daytime Phone # ______________ Cell # ______________

Birthdate __________ Age ______ Sex ______ Marital Status ______ SS# __________

E-mail Address ______________________

Patient's Occupation ______________ **Patient's** Employer ______________

Employer's Address ______________________

DENTAL INSURANCE INFORMATION

Insurance Company ______________________ Phone # ______________

Policy # ______________________ Group # ______________

Insured Name ______________ SS # ______________ D.O.B. ___/___/___

Insured Employers name ______________________

Insured Employer's Address ______________________
Street City State Zip

Insured Employer's Phone # ______________________

SECONDARY INSURANCE INFORMATION

Insured Name ______________ SS # ______________ D.O.B. ___/___/___

Insured Employers name ______________________

Insured Employer's Address ______________________
Street City State Zip

Insured Employer's Phone # ______________________

HOW LONG SINCE YOUR LAST DENTAL EXAM? ______________________

PLEASE STATE YOUR MAJOR DENTAL CONCERNS ______________________

____

____

Preferred Pharmacy Name and Phone Number: ______________________

____

Rev. 2/19

(OVER)

MEDICAL HISTORY

1. **List Physician's Name & Phone #**____________________
2. Are you now under the care of your physician at this time? If yes, what condition(s) are being treated?____________________ YES NO

   If no, date of your last physical examination____________________

Do You Now Have, or Have You Had Any Of the Following:

3. Rheumatic fever, Heart murmur **or** mitral valve prolapse? **(Please circle which)**.... YES NO
4. Heart trouble, heart attack, stroke, pacemaker, or prosthetic (artificial) heart valve? **(Please circle which)**.................................... YES NO
5. List ANYTHING artificial in your body? (Example: pins, screws, plates, joints.)....... YES NO

   ____
6. Do you have high blood pressure?.. YES NO
7. Do you have AIDS, ARC or positive antibody test to HIV/HTLV-III?.......................... YES NO
8. Thyroid disease? .... YES NO
9. Are you taking any blood thinners or aspirin? .... YES NO
10. Do you have diabetes?.. YES NO
11. Do you have hepatitis?.. YES NO
12. Do you have tuberculosis?.. YES NO
13. Do you have Asthma **or** emphysema **(Please circle which)** .... YES NO
14. Do you suffer from acid reflux or dry mouth? **(Please circle which)** .... YES NO
15. Do you suffer from chronic cold sores or fever blisters? **(Please circle which)** ...... YES NO
16. Are you interested in straightening crooked teeth with Invisalign?............................ YES NO
17. Are you interested in brightening a yellow or dark smile with a bleach system?......... YES NO
18. Are you interested in eliminating periodontal disease with a non-cutting laser instead of surgery?... YES NO
19. Are you interested in a snore guard for you or your mate to sleep more soundly?.... YES NO
20. Do you grind or clench your teeth?.. YES NO
21. Any other medical conditions that are not listed above? If yes, please list .... YES NO

    ____

List below any medications, herbs or vitamins you are presently taking, including over the counter medicines. (Example: insulin, heart, high blood pressure, blood thinner meds.)

DRUG NAME	DOSAGE	REASON

List below any allergies you have:____________________

____

____

To the best of my knowledge, all of the preceding answers are true and correct. I also certify that the diagnosis, nature of treatment, fees, payment options, risks, benefits, alternatives and consequences were answered in full and understood. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I give consent for dental treatment.

Patient ____________________ Dentist____________________

(OVER)