Kevin Haiar, DDS, Diplomate of the American Board of Oral Implantology
5200 S. Cliff Avenue, Suite 102 | Sioux Falls, SD 57108
Phone 605.799.2929 | Fax 605.252.9500
www.siouxfallsdentalimplantcenter.com | info@siouxfallsdentalimplantcenter.com

Patient Information

First Name ______________________ Last Name _________________________ Middle _____________

Preferred Name ______________________ Date of Birth ________________ Gender ☐ Male ☐ Female

Address ____

City _____________________________________ State ______________ Zip _____________________

Phone Number ____

Email Address ____

Preferred Contact Method ☐ Phone Call ☐ Text Message ☐ Email

Emergency Contact Name/Relationship ____

Emergency Contact Phone ____

Medical Doctor's Name ____

Preferred Pharmacy ____

How did you hear about our office?

☐ Doctor Referral _____________________________ ☐ Patient Referral _____________________________

☐ Internet Search/Website ☐ Other ____

Dental Insurance (please either fill out below OR provide us with your insurance card if available)

Primary Insurance Company ____

Address ____

City ____________________________ State __________ Zip ___________ Phone ____________________

Policy Holder ________________________________ Relationship to Patient _________________________

Date of Birth __________________________________ SSN _____________________________________

Group/Policy # _________________________________ ID # _____________________________________

Have any of the below ever caused an allergic or adverse reaction?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sedatives

Please List Any Other Allergies: ____

Please check any of the following health conditions that apply:

- ☐ (High/Low) Blood Pressure
- ☐ AIDS/HIV
- ☐ Anemia/Bleeding Problems
- ☐ Artificial Heart Valves
- ☐ Blood Disease
- ☐ Congenital Heart Lesions
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Arthritis/Rheumatism/Gout
- ☐ Artificial Joints/Bones
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Radiation Treatment
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors of Head or Neck
- ☐ Ulcer
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Headaches (Frequent)
- ☐ Hepatitis
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Alcohol Consumption
- ☐ Birth Control Pills
- ☐ Tobacco in any form
- ☐ Pregnant/Nursing
- ☐ Osteoporosis
- ☐ Birth Control

Please list any other diseases, medical conditions, or recent hospitalizations/surgeries:

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Please list all medications that you are currently taking (prescription and over the counter):

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I authorize the release of a full report of examination findings, diagnosis, treatment planning, etc., to any referring dentist or physician. I additionally authorize the release of any dental/medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature ______________________________ **Date** ________________