DIANE T. MCGINTY, D.M.D., M.S., P.A.

PATIENT INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Name ______________________________
First Middle Last

Nickname

Date

Address City State Zip

Phone Numbers
Home:

Work: Ext:

Cell:

Birth Date: Age:

Soc Sec: Sex: ○ M ○ F

Drivers Lic:

Patient's Occupation:

If child, parent's name:

Patient's Employer:

General D.D.S., Name and Phone No.: Referred by Other?

Patient's Physician and Phone No.

Emergency Contact Name and Number

E-mail:

DENTAL Insurance Company:

Phone Number:

Address of Insurance Co.

Name of Insured(Primary Policy Holder):

Relationship to Insured:

Insured Employer:

Insured SS:

Insured Birth Date:

Member ID #:

Group #:

Please present insurance card to receptionist with this information sheet.

PATIENT'S MEDICAL HISTORY

Yes No

○ ○ Are you in good health?

○ ○ Are you under a physician's care?

○ ○ Are you subject to prolonged bleeding?

○ ○ Have you ever had major surgery?

○ ○ Have you been hospitalized in the last 5 years?

○ ○ If Female: Are you pregnant?
What month? ____

○ ○ Do you have or been told you have TMJ problems?

○ ○ Are you allergic to or had an unusual reaction to an anesthetic, drug or pill?
List them:______________________________
____
____

○ ○ Are you taking medications now?
List them:______________________________
____
____

○ ○ Do you take oral contraceptives?

○ ○ Do you premedicate for dental treatment?

Please check any of the following which you have had or presently have.

- ☐ Heart Condition
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Heart Surgery
- ☐ Rheumatic Fever
- ☐ Prolapsed Mitral Valve
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Stroke
- ☐ Anemia
- ☐ Asthma
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ HIV
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Chemo/Radiation Therapy
- ☐ Psychiatric Treatment
- ☐ Blood Disorders
- ☐ Respiratory, Lung Disease
- ☐ High Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Artificial Joint Replacement
- ☐ Cancer
- ☐ Epilepsy

Is there any other information we should know about your health?
____
____
____
____

____
Signature of Patient, Parent, or Agent Date