Virden Dental Care

140 E. Dean St.

Virden, IL 62690

PATIENT INFORMATION

Date: _____

Name_____ Birthdate _____ S.S. # _____

Address_____ City _____ State_____ Zip _____

Primary phone: _____Alt. phone: _____Email: _____

Spouse/Parent_____ Phone_____

Emergency contact_____ Phone: _____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber name_____ Birthdate_____ ID#/SSN_____

Employer_____ Insurance Co._____ Group#_____

MEDICAL HISTORY

1. Do you have any allergies to medications or materials such as latex? ❒ YES ❒ NO

   If yes, please specify_____

2. Do you use any of the following (please circle): Tobacco Alcohol Recreational Drugs

3. Please list ***ALL*** medications you are currently taking in the space provided below:

   _____

   _____

Please mark any of the following that applies to you.

❒ High Blood Pressure	❒ Joint replacement	❒ Osteoporosis
❒ Heart attack	❒ Cancer	❒ Pregnant
❒ Pacemaker	❒ Radiation/ Chemotherapy	❒ Nursing
❒ Excessive bleeding	❒ Diabetes	❒ Asthma/Breathing
❒ HIV/AIDS	❒ Stroke	❒ Seizures
❒ Hepatitis	❒ Other: _____	

_____

_____