PATIENT INFORMATION SHEET

Last Name	First Name	MI	Title Mr. Mrs. Ms. Miss. Dr.
Home Street Address	City	State	Zip
Home Phone ( )	Business Phone ( )	Cell Phone ( )	Sex M F
Social Security Number --- ----	Date of Birth / /	Driver's License #	Nickname
Patient Employed by		Occupation	
Employer Address	City	State	Zip
Marital Status: ☐ Single ☐ Married ☐ Other:	E-Mail:		

Spouse/Guardian Last Name	Spouse/Guardian First Name	MI
Spouse/Guardian Employer Name	Occupation	
Spouse/Guardian Business Address	City	State	Zip
Spouse/Guardian Business Phone ( )	Spouse/Guardian Social Security Number ---- -----	Date of Birth / /

Name of Dental Insurance Company:	Name of Main Subscriber to Insurance:	
Is Treatment covered by insurance? Yes No	Group Number:	Name of Employer providing insurance
Name of General Dentist Phone # ( )	Name of Physician Phone # ( )	
In case of emergency, whom to notify:	Relationship	Phone # ( )
If patient is a minor, Give name and phone # of person legally responsible:		Phone # ( )

Your portion of the co-insurance will be collected on the day of treatment. Method of Payment:
☐ Cash ☐ Check ☐ Visa ☐ MC ☐ Discover

I acknowledge that the information provided above is correct. I understand that all information will be kept confidential and will only be used to process insurance claims. No confidential information will be released to a third party (with an exception of insurance company) without my prior knowledge and consent.

Signature _____ Date _____

MEDICAL HISTORY

Please complete the following questions. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

Circle Answer

1. Are you in good health?…… Yes No
   If no, please specify _____

2. Are you under the care of a physician for a current problem?…… Yes No
   Nature of treatment _____

3. Have you been hospitalized within the past five years?…… Yes No
   Reason _____

4. Are you taking any medications or drugs?…… Yes No
   Name of medication _____
   What condition is being treated? _____

5. Can you take NSAID medications like Advil, Ibuprofen, Aleve or Naprosyn?……..……... Yes No

6. Do you take blood thinners? Medication? _____ Yes No

7. Have you ever had surgery and/or radiation treatment to the head or neck? …… Yes No

8. Have you ever been tested for HIV infection (AIDS)? …… Yes No
   Result of the test Date _____ Positive or Negative

9. Please specify any ALLERGIC OR ADVERSE REACTIONS you have ever had to anesthetics, latex, anti-biotic, or other medications:_____

10. Have you ever taken medications for osteoporosis or osteopenia like Boniva/Fosamax/Aredia……..…….. Yes No

11. Do you have or have you had any of the following: (please circle)

Heart murmur or prolapsed valve (MVP)	Y/N	Diabetes	Y/N
Prosthetic heart valve	Y/N	Stomach ulcers, colitis or IBS	Y/N
Joint prosthesis (hip, knee, etc.)	Y/N	Hepatitis A B C	Y/N
Rheumatic fever or rheumatic heart disease	Y/N	Jaundice or liver disease	Y/N
Congenital heart disease	Y/N	Dialysis or kidney problems	Y/N
Cardiovascular disease	Y/N	Depression or psychiatric disorder	Y/N
Heart attack or Chest Pain	Y/N	Epilepsy, fainting spells or seizures	Y/N
Stroke or TIA	Y/N	Cancer	Y/N
Blood disorder (e.g. Anemia)	Y/N	Temporomandibular joint problems(TMJ)	Y/N
Asthma or sinus trouble	Y/N		
Thyroid problems	Y/N		

12. Do you have any disease, condition or problem not listed above? ……. Yes No
    Please specify: _____

13. Are antibiotics required prior to dental treatment? ……..….. Yes No

Women:

14. Are you pregnant? …… Yes No

15. Do you take birth control pills? …… Yes No
    If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

16. Are you nursing? …….. Yes No

All of the above information is true to the best of my knowledge.

Signature of Patient _____ Date _____
All signatures must be by parent or guardian if patient is under the age of 18.

Reviewed By Dr. Ida _____RI on _____/_____/_____