PATIENT INFORMATION

DENTAL INS. ❑ YES ❑ NO REFERRING DENTIST _____

NAME _____ DOB _____ SEX ____

HOME ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

S.S.# _____ **EMAIL ADDRESS** _____

EMPLOYER _____ ❑ RETIRED ❑ STUDENT

BUSINESS ADDRESS _____ BUSINESS PH. _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE NAME: _____ ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER

SECONDARY INSURANCE NAME: _____ ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER

NAME IF OTHER THAN SELF _____

S.S.# _____ DOB _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____ ❑ RETIRED

BUSINESS ADDRESS _____ BUSINESS PH. _____

CITY _____ STATE _____ ZIP _____

ALTERNATE EMAIL ADDRESS _____

HEALTH QUESTIONNAIRE

Information about your health will be held as confidential by this office and will be released only upon your expressed consent. Many general health factors may affect your oral health and influence our treatment. Therefore, it is important for you to complete this form accurately and in entirety. Thank you.

Medical Doctor _____ Phone Number _____

Last Visit For _____ Date _____

Are you currently under a physician's care? _____ For what condition? _____

List medications taken in the last month _____ **(or see list provided ❑)**

_____

_____

MEDICATION ALLERGIES: _____

Do you or have you ever had any of the following: Latex **Allergy** ❑ **Yes** ❑ **No** **Premed required?** ❑ **Yes** ❑ **No**

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation treatments
___ Excessive bleeding
___ Allergies to anesthetics:
Dental ❑
Medical ❑
___ Anemia
___ Arthritis
___ Asthma
___ Childhood diseases
___ Diabetes
___ Hepatitis
___ Kidney Disease
___ Malignancies
___ Noise in Ears
___ Psychiatric care
___ Rheumatic Fever
___ Syphilis
___ Scarlet Fever
___ Sinus Problems
___ Slow Healing
___ Stroke
___ Tuberculosis
___ Ulcer
___ Are you pregnant
___ Positive test for HIV virus
___ NONE OF THESE APPLY

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possbily affect your dental treatment _____

_____

SIGNATURE _____ DATE _____

EMERGENCY CONTACT & PHONE # _____

HIPPA (Privacy Policy): given to pt__ by:___; Acknowledgement Hippa presented: _____(pt initial)

COVOID RELEASE: given to pt__ by:___; Presented & Pt Release Acknowledgement:

PATIENT TEMP @ APPT_____ _____(pt signature)