Patient Confidential Information

Patient:

Name: Mr. Mrs. Miss Dr. _____ (First) ___ (M.I.) _____ (Last) Birthdate: _____ (Month) _____ (Day) _____ (Year)

Name that you wish to be called: _____ School you are attending: _____

Social Security #: ___-___-___ Driver's License #: _____ Home Phone #: (___) _____

Home Address: _____ (Street) _____ (Apartment) Mobile Phone #: (___) _____

_____ (City) ___ (State) _____ (Zip Code) E-mail Address: _____

Employer: _____ Occupation: _____ Work Phone #: (___) _____

Spouse Name: _____ (First) ___ (M.I.) _____ (Last)

Children's Names and Ages: _____

Emergency Contact: _____ (First) ___ (M.I.) _____ (Last) Best Phone #: (___) _____

Physician Name: Dr. _____ (First) ___ (M.I.) _____ (Last) Work Phone #: (___) _____

Medical / Dental: *Answer each item for which you had or presently have. Either circle "Yes" or "No," or write in your response.*

Heart Disease ..... Yes No
Heart Attack .... when? ..... Yes No
Heart Murmur ..... Yes No
Mitral Valve Prolapse ..... Yes No
Artifical Heart Valve ..... Yes No
Heart Pacemaker ..... Yes No
High Blood Pressure ..... Yes No
Low Blood Pressure ..... Yes No
Rheumatic Fever ..... Yes No
Stroke .... when? ..... Yes No
Diabetes .... (childhood or adult) ..... Yes No
Tobacco Use .... years? ..... Yes No
Tuberculosis ..... Yes No
Cancer .... type? ..... Yes No
Chemotherapy ..... Yes No
Radiation Therapy ..... Yes No
H.I.V. or A.R.C. ..... Yes No
Bulimia ..... Yes No

Hepatitis .... (A or B or C) ..... Yes No
Bisphosphonate use ..... Yes No
Seizures .... (grand or petite) ..... Yes No
Artifical Joints (i.e. hip or knee) ..... Yes No
Current Pain in Mouth ..... Yes No
Gagging during dental treatment ..... Yes No
Bleeding during brushing ..... Yes No
Loosening of your teeth ..... Yes No
Periodontal or Gum Disease ..... Yes No

Orthodontic Treatment (i.e. braces) ..... Yes No
Bleaching .... (past or present) ..... Yes No
Grinding or Clenching .. (day or night) .... Yes No
Jaw Popping or Clicking ..... Yes No

Women:
Current Pregnancy .... month? ..... Yes No
Currently Nursing ..... Yes No
Taking Birth Control Medication .... Yes No

List your diseases, conditions, or problems **not** written above: .....
.....
When was your last medical examination? .....
Are you in good health? ..... Yes No

Current Medication	Dose	Frequency	Purpose	Since

Circle or list any allergies:
Latex Codeine Nickel
Sulfites (not sulfa) Penicillin
Other Antibiotic .....
Other Medication .....

What is your present dental concern? .....
How often do you floss your teeth? .....
Who was your previous dentist? .....
Describe any unhappy dental experiences you had: .....
.....
Do you take premedication before dental visits? .... type? ..... Yes No

Consent:

1. To the best of my knowledge, all of the preceding answers are true.
2. If I have any changes in my health or medications, I will inform the doctor at my next appointment.
3. I grant permission to this office to contact my healthcare providers for details regarding any of my medical conditions.
4. Copies of the Dental Materials Fact Sheet and the Notice of Privacy Practices have been provided to me.
5. I permit this office to take x-rays and to use any other diagnostic aids necessary to evaluate my dental needs.
6. I authorize this office to perform all required treatment with the appropriate medications and therapeutic agents.

Signature of responsible party: _____ Date: _____ Relation to patient: _____

Office initials: _____

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