PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name ______________________ Preferred name ____________ Birth date __________

If minor, guardian name(s) ______________________ Email address ______________

Home phone ______________ Work phone ______________ Cell phone ______________

Mailing address ______________________ City ____________ State ______ Zip ________

Employer ______________________ Occupation ______________________

Spouse's name ______________________ Spouse's employer ______________________ ❑ Unmarried

Whom may we thank for referring you to our office? ______________________ ❑ Online

BILLING, CREDIT, AND INSURANCE INFORMATION:

❑ Not covered by dental insurance

Your Social Security number: ______________ Dental Insurance Co. ____________ Group number __________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________ Group number ____________

Spouse's birthday ______________ Social Security number ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

- ❑ Have you been admitted to the hospital or had any surgeries in the past 5 years? Please explain ________
____
____

- ❑ Please list current medications, Prescription or Over the counter ______________________
____
____
____
____
____
____

Are you taking or have you ever taken Bisphosphonates? (i.e. Fosamax, Boniva)? If yes, when? ______________

- ❑ Are you allergic to, or have you reacted adversely to any of the following?
  - ❑ Latex materials
  - ❑ Penicillin or other antibiotics
  - ❑ Local anesthetics ("Novocain")
  - ❑ Codeine or other narcotics
  - ❑ Sulfa drugs
  - ❑ Barbiturates, sedatives, or sleeping pills
  - ❑ Aspirin
  - ❑ Other: ______________________

Women:

- ❑ May be pregnant
  Expected delivery date: ____________

Name of your physician:____

Do you have any disease, condition, or problem not listed above?____

____

When was your last dental visit?____

Is there anything you dislike about your teeth or smile? ____

Please add anything else you would like us to know about:____

____

Emergency Contact Information:

Name:______________________ Phone Number: ____________________ Relationship to Patient:___________________

I hereby authorize Dr. Gray to furnish information to insurance carriers concerning this exam or treatment and I hereby irrevocably assign to the doctor all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of patient (or guardian) ___________________________________ Date ______________