PRECISION DENTAL

DATE _____

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, PARENTS NAMES _____ HOME PHONE _____ **CELL PHONE** _____

BUSINESS PHONE_____

EMAIL ADDRESS _____ PREFERRED METHOD OF CONTACT ☐ HOME ☐ WORK ☐ CELL ☐ EMAIL

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ ❑ UNMARRIED

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ ❑ PHONEBOOK

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ NOT COVERED BY DENTAL INSURANCE

YOUR SOCIAL SECURITY NUMBER _____ DENTAL INSURANCE _____ GROUP # _____

COVERED BY SPOUSE'S INSURANCE? ❑ YES ❑ NO

SPOUSE'S DENTAL INSURANCE COMPANY _____ GROUP # _____

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)

- ❑ ABNORMAL BLEEDING AFTER EXTRACTIONS, SURGERY, OR TRAUMA
- ❑ AIDS OR HIV POSITIVE
- ❑ ALCOHOLISM
- ❑ ALLERGIES OR HIVES
- ❑ ANEMIA OR BLOOD DISORDERS
- ❑ ARTHRITIS
- ❑ ARTIFICIAL JOINT OR VALVE
- ❑ ASTHMA
- ❑ BLOOD TRANSFUSION
- ❑ CANCER OR TUMOR
- ❑ DIABETES
- ❑ EMOTIONAL CONDITION
- ❑ EPILEPSY, SEIZURES, OR FAINTING SPELLS
- ❑ HAYFEVER OR SINUS TROUBLE
- ❑ HEART AILMENT OR ANGINA
- ❑ HEART MURMUR, MITRAL VALVE PROLAPSE, HEART DEFECT
- ❑ HEPATITIS OR OTHER LIVER DISEASE
- ❑ HERPES OR COLD SORES
- ❑ HIGH BLOOD PRESSURE
- ❑ KIDNEY DISEASE
- ❑ LUPAS
- ❑ MIGRAINE HEADACHES OR FREQUENT HEADACHES
- ❑ NEUROLOGIC CONDITION
- ❑ PACEMAKER
- ❑ RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE
- ❑ STROKE
- ❑ THYROID DISEASE
- ❑ TUBERCULOSIS OR OTHER LUNG PROBLEMS

DO YOU SMOKE OR USE CHEWING TOBACCO? ❑ YES ❑ NO

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

- ❑ ASPIRIN
- ❑ BARBITURATES, SEDATIVES, OR SLEEPING PILLS
- ❑ CODEINE OR OTHER NARCOTICS
- ❑ LATEX MATERIALS
- ❑ LOCAL ANESTHETICS ("NOVOCAIN")
- ❑ PENICILLIN OR OTHER ANTIBIOTICS
- ❑ SULFA DRUGS
- ❑ OTHER:_____

ARE YOU TAKING ANY OF THE FOLLOWING?

- ❑ ANTIBIOTICS OR SULFA DRUGS
- ❑ ANTICOAGULANTS (BLOOD THINNERS)
- ❑ ANTIDEPRESSANTS OR TRANQUILIZERS
- ❑ ASPIRIN
- ❑ BISPHOSPHONATE
- ❑ CORTISONE OR OTHER STEROIDS
- ❑ HIGH BLOOD PRESSURE MEDICINE
- ❑ INSULIN, ORINASE, OR OTHER DIABETES DRUG
- ❑ NITROGLYCERIN
- ❑ OSTEOPOROSIS (BONE DENSITY) MEDICINE
- ❑ LIST OF MEDICINES:

_____

_____

WOMEN:

- ❑ PREGNANT OR MAY BE PREGNANT
  EXPECTED DELIVERY DATE: _____
  ❑1ST ❑2ND ❑3RD TRIMESTER
- ❑ NURSING
- ❑ TAKING HORMONES OR CONTRACEPTIVES

NAME OF YOUR PHYSICIAN: _____ PHYSICIAN OFFICE PHONE: _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?_____

PLEASE ADD ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT:_____

I AM INDICATING MY CONSENT FOR ROUTINE DENTAL PROCEDURES SUCH AS X-RAYS, CLEANINGS, FILLINGS, CROWNS, AND LOCAL ANESTHESIA. IF I AM COMPLETING THIS FORM FOR A MINOR, I CERTIFY THAT I AM RESPONSIBLE FOR THE MEDIAL/DENTAL CARE OF THE MINOR.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) _____ DATE _____

SIGNATURE OF STAFF WITNESS _____ DATE _____

MEDICAL HISTORY UPDATE

DATE	COMMENTS	SIGNATURE