Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

Gender: Male Female Family Status: Married Single Child Other

Birth Date: ______________ Social Security#:___________________ Email:______________________________

Phone (Home): ________________(Work): ________________(Cell):________________ Best time to call:_____________

Address: ____
Street City State Zip Code

Driver's License # ___________________

Emergency Contact:____
Name Phone # Relationship to you

Referral Information

Whom may we thank for referring you to our practice? ☐ Yellow Pages ☐ Davis Phone Book ☐ Internet

Name of person, office, or other source referring you to our practice: ___________________________________

Insurance Subscriber Information

Name: ____

Patient's Relationship to Subscriber: Self Spouse Child Other

Insurance Company Name ____

Birth Date: _______________ Social Security #:____________________ or Subscriber ID #____________________

Employment Information

The following is for: ☐ the insurance subscriber ☐ the person responsible for payment

Employer Name: ___________________________________ Occupation: ____________________________________

Address: ____
Street City State Zip Code

Phone#__________________

Medical History

Primary Care Physician: ____
Name Phone #

Are you currently under the care of a physician? **Yes No**
If yes, what is the condition being treated?____________________________

Have you had any illnesses or surgeries we need to be aware of? **Yes No**
If yes, please explain: ____________________________________

Have you been hospitalized in the last year? **Yes No**
If yes, what for? ________________________________

Have you ever had any of the following? Please check those that apply:

☐AIDS or HIV	☐Arthritis	☐Artificial Joints	☐Blood Disorder	☐Asthma
☐Cancer or Tumor	☐Thyroid Problems	☐Diabetes	☐Chemo or Radiation Tx	☐ Glaucoma
☐ Excessive Bleeding	☐ Fainting	☐Tuberculosis	☐Epilepsy or Seizures	☐Hepatitis
☐ High Blood Pressure	☐ Kidney Disease	☐Liver Disease	☐ Nervous or Mental Disorders	☐Stroke
☐ Drug Addiction	☐Rheumatic Fever	☐TMJ Problems	☐ Immune System Disorders	☐ **NONE**

Have you ever had any condition related to your HEART (heart attack, murmur, stent, valve, pacemaker)?Yes No

Do you have any other health concerns or conditions that we need to know about? **Yes No**

If yes, please explain: ____

MEDICATIONS

Are you currently taking any medications or recreational drugs? **Yes No**

Please list here and <u>what they are for</u>:____

____

Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? **Yes No**

Have you ever used Phen-Fen or similar appetite suppressant? **Yes No**

Have you ever taken Fosamax, Boniva, Aredia, or any drugs prescribed to decrease resorption of bone? **Yes No**

Do you use Tobacco (smoking or chewing)? How often? ______________/day **Yes No**

WOMEN ONLY

Are you pregnant? **Yes No** Due Date__________ **Are you currently taking birth control?** **Yes No**

ALLERGIES

Are you allergic, or had any negative reactions to any of the following:

☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Latex ☐Other __________ ☐NONE

Dental History

Have you ever had any severe reaction to dental treatment or local anesthetics? **Yes No**
If yes, please explain: ____

Please mark any of the following to indicate Yes in response to the question:

☐Do your gums bleed when you brush or floss?
☐Do your teeth experience sensitivity to cold or hot temperatures?
☐Do you grind your teeth (either consciously or during sleep)?
☐Do you snore or gasp while sleeping?

If any of the previous questions are marked, please explain:____

Please bring your insurance card and driver's license to the front desk, along with your completed forms where you will electronically sign them.