Patient Information Form

In order to serve you properly, we need the following information. All information is strictly confidential. Please Print clearly.

Referred By _____ Preferred appt. time & day _____ Preferred Dentist_____

Patient Name _____ Birthdate _____ Gender Male__ Female__0ther_____
(Last) (First) (Middle)

GENERAL

Social Security # _____-_____-_____ Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widow☐

Address _____ City _____State_____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Occupation_____ If student, name of school _____

Employer _____ Work Phone ( ) _____ Ext. _____

Address _____ City _____ Zip Code _____

Name of Spouse (or parent/legal guardian if under 18) _____ Phone ( ) _____

Address_____ SSN of spouse (or guardian if under 18) ____-____-____

In case of emergency- Name of nearest relative or friend _____

Address _____City_____ Zip Code _____ Phone ( ) _____

Do we have your permission to discuss financial, medical, and personal information on your cellular phone? YES / NO

If not, please provide other phone #_____

MEDICAL

Chief complaint/ Reason for visit _____

List any allergies you have (latex, drugs, food, pollen, animals, etc.) _____

List any medications, vitamins, herbs you are taking _____

( ) See attached list (ask receptionist for a separate medication list if more space is needed)

Have you taken diet pills containing "fen-phen", fenfluramine (Pondimin), dexfenfluramine (Redux) YES / NO?

Are you taking medicine for Osteoporosis? YES / NO For How Long? _____

Circle name: Bisphosphonates Fosamax Actonel Boniva Areda I.V. Reclast I.V. Zometa I.V.

Other medications_____

Describe any condition we should know about _____

Do you wish to talk to the dentist privately about any problem? YES NO

Do you have: Dry Mouth (Xerostomia)? YES / NO Snoring? YES / NO Obstructive sleep apnea? (OSA) YES / NO CPAP? YES / NO
TMJ/TMD pain? YES / NO High cholesterol? YES / NO High Blood Pressure? YES / NO Diabetes? YES / NO Asthma? YES / NO

By signing below, I have reviewed and answered every question completely and accurately; if anything changes, I will inform my dental care provider as soon as possible.* A medical consultation may be necessary before providing dental treatment for your health and safety. MD name and phone number _____

X_____ _____ _____ _____ _____

Patient signature or Parent/legal guardian if minor Date Staff Initial Dentist Signature Date Reviewed

Revised 4/2/2021