PATIENT INFORMATION FORM

Today's Date: _____

Patient Information:

Last Name:_____First Name:_____Middle Initial: _____

Sex: M [ ] F [ ] Date of Birth:_____Age:_____Social Security #: _____

Address: _____

Apt #:_____City:_____State:_____Zip Code: _____

Employer:_____Driver's License #: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

E-mail address: _____

Responsible Party Information: (If address is the same as above, please leave blank.)

Last Name:_____First Name:_____Middle Initial: _____

Marital Status:_____Date of Birth:_____Age:_____Social Security #: _____

Address: _____

Apt #:_____City:_____State:_____Zip Code: _____

Employer:_____Driver's License #: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

E-mail address:_____Relationship to Patient: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name:_____Relationship:_____

Home Phone:_____Work Phone: _____

How would you like to pay for this visit? [ ] Insurance [ ] Medicaid [ ] TX CHIP [ ] Credit Card [ ] Cash

Are you interested in teeth whitening? [ ] Yes [ ] No

How did you hear about us? _____

Reason for today's visit: _____

Medical History:

Are you under a physician's care now? [ ] Yes [ ] No If yes, please explain: _____

Date of last physical exam: _____

Have you ever been hospitalized? [ ] Yes [ ] No If yes, provide date you were hospitalized: _____

Reason for hospitalization: _____

Date of last physical exam: _____

Do you smoke or chew tobacco? [ ] Yes [ ] No If yes, how often per day?_____How long? _____

Have you ever taken Fosamax, Boniva, Actonel or any other meds containing Biophosphonates? [ ] Yes [ ] No

WOMEN: Are you pregnant? [ ] Yes [ ] No If yes, how long?_____Taking Birth Control Pills? [ ] Yes [ ] No

Breast Feeding? [ ] Yes [ ] No Taking hormonal replacement? [ ] Yes [ ] No

Place a mark on "**Yes**" or "**No**" to indicate if you have had any of the following:

- Heart disease that was detected at birth..... ☐ Yes ☐ No
- Rheumatic fever or Rheumatic heart disease..... ☐ Yes ☐ No
- Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)..... ☐ Yes ☐ No
- Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath)..... ☐ Yes ☐ No
- Neurologic Disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)..... ☐ Yes ☐ No
- Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)..... ☐ Yes ☐ No
- Liver Disease (jaundice, hepatitis)..... ☐ Yes ☐ No
- Kidney Disease..... ☐ Yes ☐ No
- Diabetes..... ☐ Yes ☐ No
- Thyroid Disease (hypothyroidism, tumor)..... ☐ Yes ☐ No
- Arthritis..... ☐ Yes ☐ No
- Stomach ulcers or Intestinal problems..... ☐ Yes ☐ No
- Glaucoma..... ☐ Yes ☐ No
- Frequent or recurring mouth sores..... ☐ Yes ☐ No
- Implants/artificial joints anywhere in your body (Heart valve, hip, knee)..... ☐ Yes ☐ No
- Radiation (X-Ray treatment for cancer) in head and neck region..... ☐ Yes ☐ No
- Noises in jaw joint, pain near ear when chewing (Do you grind or clench your teeth?)..... ☐ Yes ☐ No
- Sinus or nasal problems..... ☐ Yes ☐ No
- Any disease, drug or transplant operation that has depressed your immune system..... ☐ Yes ☐ No
- Recurrent infections of any kind..... ☐ Yes ☐ No

Please "**check**" if you are taking or using any of the following:

[ ] Antibiotics
[ ] Thyroid Medications
[ ] Antihistamines Decongestants
[ ] Steroids
[ ] Anticoagulants (blood thinners)
[ ] Antacids
[ ] High blood pressure or heart medications
[ ] Tranquilizers or Antidepressants

Have you ever been advised NOT to take a medication? ☐ Yes ☐ No _____

Please list all current medications here: _____

_____

Please "**check**" if you are allergic to or had a bad reaction from:

[ ] Local Anesthetics
[ ] Codeine or other narcotics
[ ] Ibuprofen or any other pain meds
[ ] Sulfa Drugs
[ ] Metal of any kind
[ ] Penicillin or other antibiotic
[ ] Barbiturates, sedatives, or sleeping pills
[ ] Aspirin
[ ] Latex
[ ] Other: _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate. If there are any changes in my health history or any medicine changes, I will inform my dentist at the next appointment.

_____ _____

Patient/Parent/Legal Guardian Signature Date