Patient Information Form

Name ____ Age _________ Birth date _______________ Sex ______
Last First Middle Initial

Social Security # ________________________________ Driver's License ____________________

Home Address ___________________________________ City ____________________ State ______ Zip _________

Home Phone ______________________ Cell Phone ______________________ E-mail Address: ________________

Employer ___________________________Occupation ______________________ Marital Status ________________

General Dentist: ___________________________

Whom may we thank for referring you to us? __________________________ Phone _______________________

Insurance Information

Primary Dental Insurance:______________________ Name of the subscriber

Employer

Birth date________________ Social Security#

Secondary Dental Insurance: _____________________ Name of the subscriber **_____________________________**

Employer

Birth date ________________ Social Security # ______________________________

Emergency Contact Information

Name___________________________________ Relationship____________________ Phone
Last First

What is the reason for your visit today? ____

Have you been hospitalized or had emergency treatment in a hospital in the past 5 years?
Yes No Why? ____

Have you been under a doctor care in the past 2 years? **Yes** **No**
Why? ____

Physician's Name: ____ **Phone**_____________

Have you had problems with prior dental treatment? **Yes** **No**

Do you use tobacco regularly? **Yes** **No**

Are you allergic to latex? **Yes** **No**

Are you currently taking the following medication?

Anticoagulant /Blood thinner	yes	no	Heart Medication	yes	no
Lung or Breathing Medication	yes	no	Nitroglycerine	yes	no
Cortisone/Steroid	yes	no	Blood Pressure Meds	yes	no
Insulin	yes	no	Aspirin	yes	no

Do you fill prescriptions at Kaiser? Yes No* ***If no, which pharmacy do you prefer?**
Are you currently taking any other medication?
If yes, Please list:_______________________________________ ***Please provide pharmacy phone number**
Are you allergic (or have you had a bad reaction) to any medications or food? Yes No
If yes, please list: Medicine______________________ Reaction_______________________
Medicine______________________ Reaction_______________________
Other(s)________________________

Do you have or have you had?

Heart Problem	yes	no	Lung Problem	yes	no	Diabetics	yes	no
Heart Murmur	yes	no	Venereal Disease	yes	no	Ulcers	yes	no
Rheumatic Fever	yes	no	Sinus Problem	yes	no	Arthritis	yes	no
Scarlet Fever	yes	no	Liver Disease	yes	no	Stroke	yes	no
High Blood Pressure	yes	no	Hepatitis/Jaundice A,B,C	yes	no	Cancer	yes	no
HIV+/ARC/AIDS	yes	no	Alcohol/Drug Problem	yes	no	Radiation	yes	no
Blood Disease/Anemia	yes	no	Psychiatric Treatment	yes	no	Asthma	yes	no
Kidney Disease	yes	no	Epilepsy/Seizures	yes	no			

Have you ever taken any of the group collectively referred to as "fen-phen"? These include combination of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine), Fosamax, Actonel or Boniva, Bisphosphonate? **Yes** **No**

Have you had placement of an artificial joint, prosthetic heart valve, implant or pacemaker?
Yes No ____

Are you subject of prolonged bleeding? Yes No ____________________________________

Do you have difficulty opening your mouth or popping/clicking or pain in your jaw joints (TMJ)?
Yes No ____

Women only: Are you or could you be pregnant? Nursing? (Please clarify) Yes No __________________
Are you taking birth control pills? Yes No __________________

Do you have any other medical condition that we should know about? __________________________

Patient/Parent/Guardian SIGNATURE _________________________________ **Date** ________________
Doctor Signature ____ **Date** __________________