

# PATIENT INFORMATION

Welcome to our office EASY FAMILY DENTAL! 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 _____             | Work phone _____                   |
| Mailing address _____  | City _____                   | State _____ Zip _____              |
| Employer _____   | Occupation _____             |                                    |
| Spouse's name _____  | Spouse's employer _____      | <input type="checkbox"/> Unmarried |
| Whom may we thank for referring you to our office? _____   |                              | <input type="checkbox"/> Phonebook |
| BILLING, CREDIT, AND INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance |                              |                                    |
| Your Social Security number: _____   | Dental Insurance Co. _____   | Group number _____                 |
| Covered by spouse's insurance? <input type="checkbox"/> yes <input type="checkbox"/> no              |                              |                                    |
| Spouse's dental insurance company _____  | Group number _____           |                                    |
| 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)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco?  yes  no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: \_\_\_\_\_

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: \_\_\_\_\_

Women:

- May be pregnant  
Expected delivery date: \_\_\_\_\_
- Taking hormones or contraceptives

Name of your physician: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above? \_\_\_\_\_

Please add anything else you would like us to know about: \_\_\_\_\_

Signature of patient (or parent) \_\_\_\_\_ Date \_\_\_\_\_