DENTAL CARE PROFESSIONALS

Patient Information

Date_____

Patient_____

Address_____

City_____

State_____ Zip_____

Email_____

Sex ☐ Male ☐ Female

Birthdate_____ Age _____

Home Number _____

Cell Number_____

Do you have dental insurance? _____

Social Security # (if insured) _____

Occupation_____

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone _____

Marital Status ☐ Single ☐ Married

☐ Partnered ☐ Divorced ☐ Widowed

Spouse's Information

Spouse's Name_____

Social Security # (if policy holder) _____

Birthdate_____

Employer_____

Health History

Has there been any changes in your health since your last visit? _____

Do you have any artificial joints, artificial heart valves, or pacemaker? _____

Have you been hospitalized or had any recent surgeries? _____

Medications

What is your pharmacy name and number? _____

List any medications that you are currently taking with the coordinating diagnosis (including over the counter medications) _____

_____

Emergency Contact

Name_____

Relationship_____

Home Number_____

Work/Cell Number_____

Allergies

☐ Aspirin ☐ Penicillin ☐ Sulfa ☐ Latex

☐ Codeine ☐ Iodine ☐ Local Anesthetic

☐ Other_____