

# AFFORDABLE FAMILY DENTAL

Patient's name \_\_\_\_\_ Preferred \_\_\_\_\_ Patient DOB \_\_\_\_\_

If minor, parents or responsible party name(s) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Permitted to leave messages on Home or Cell Phone?  Yes  No

Email address \_\_\_\_\_

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_  Unmarried

Whom may we thank for referring you to our office? \_\_\_\_\_

**BILLING, CREDIT, AND INSURANCE INFORMATION:**  Not covered by dental insurance

Insured's Social Security number: \_\_\_\_\_ Dental Ins Co. \_\_\_\_\_ ID \_\_\_\_\_

Insured's DOB \_\_\_\_\_

Covered by spouse's or other insurance?  yes  no

Spouse's dental insurance company \_\_\_\_\_ ID number \_\_\_\_\_

Spouse's DOB \_\_\_\_\_ 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: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Medications: \_\_\_\_\_

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