Patient Information

Welcome to Azalea Road Dental! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient Name:_____ Preferred name:_____ Date of Birth:_____
Parents' names (minor):_____ Sex: M F Marital Status: Single Married Divorced Widowed
Home Phone:_____ Work phone: _____ Cell phone: _____ Email: _____
Mailing address:_____ City_____ State_____ Zip_____
Employer:_____ Occupation:_____
Whom may we thank for referring you to our office?_____

Billing, Credit, and Insurance Information: Covered by dental insurance: Yes No
Patient SS#:_____ Dental Insurance Provider:_____ Group Number:_____
Covered by spouse's insurance: Yes No
Spouse's name:_____ Date of Birth:_____ SS#_____
Employer:_____ Occupation:_____ Dental Insurance Provider:_____
Group Number:_____
Emergency Contact:
Name:_____ Relationship:_____ Home Phone:_____ Cell phone:_____

Medical Health History

Do you have, or have you had any of the following?

- ☐ Cancer or tumor
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Heart valve replacement, ***knee replacement, hip replacement, joint replacement, etc.***
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition (stroke, aneurysm, etc.)
- ☐ Epilepsy, seizures, or fainting spells
- ☐ 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
- ☐ Hay fever 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 steroid
- ☐ Osteoporosis (bone density) medicine
- ☐ Other:_____

Women:

- ☐ May be pregnant
  Expected delivery date:_____
- ☐ Taking hormones or contraceptives (birth control pills)

Name of your physician:_____

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

_____

_____

Please list **all** medications you take ***daily* or *regularly***:

_____

_____

Signature of patient (or parent)_____ **Date**_____