PATIENT INFORMATION:

Patient Name: _____BirthDate: _____/____/_____
Last First MI

Address_____
Street Apt# City State Zip Code

Phone Number: ( ) - Alt Number ( ) - Sex (Circle One) M F

Email_____ Marital Status (Circle One) S M D W

SS#_____ DL# _____State_____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION:

Insurance Company_____ Subscriber SS# or ID#_____

Name of Insured_____BirthDate: _____/____/_____

Employer_____ Relationship to Patient_____

Authorization:

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I am aware the expected insurance portion is an estimate only give in good faith based on information available from my insurance. I understand that I am responsible for all costs of dental treatment not paid by my insurance plan.

Signature of
Patient/Parent_____Date_____/____/_____

EMERGENCY CONTACT_____#_____

HEALTH HISTORY:

Name of General Physician_____ Phone Number: ( ) -

Date of Last Medical Exam_____/____/_____ Are You Currently Under the Care of a Physician? Y N

Yes?(Reason):_____

_____

How would you describe your overall health? (Circle one) Poor Fair Good Excellent

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE AND WHY:

Please check here if you have included a separate list ☐

MEDICATION	PURPOSE

Current Conditions (please circle either yes or no):

Heart Murmur	Y	N	Anemia	Y	N	Diabetes Type__	Y	N
Epilepsy	Y	N	Hepatitis Type_____	Y	N	Previous Rheumatic Fever	Y	N
Asthma	Y	N	HIV/AIDS	Y	N	Mitral Valve Prolapse	Y	N
Respiratory Disease	Y	N	Kidney Disease	Y	N	Heart Disease	Y	N
Nervous Disorders	Y	N	Mental Disorders	Y	N	Venereal Disease	Y	N
Sore/Enlarged Lymph Nodes	Y	N	Previous Biopsies	Y	N	Slow Healing Mouth Sores	Y	N
Other Infections	Y	N	Abnormal Bleeding	Y	N	Glaucoma	Y	N
Liver Disease	Y	N	Abnormal Weight Change	Y	N	High Blood Pressure	Y	N
Acid Reflux	Y	N	Digestive Issues	Y	N	Sinus Disorders	Y	N
Joint Replacement	Y	N	Replacement Type_____			When____/_____/_____		

Allergies (Please circle if allergic):

Latex	Penicillin	Aspirin
Codeine	Local Anesthetics	Other/Food:_____

Any other health conditions/allergies not listed above_____

Have you been hospitalized in the last 5 years? Y N

Yes?Reason:_____

_____

Have you ever been told to Pre-Medicate prior to dental visits? Y N

Do you consume grapefruit juice/extract Y N

Do You Use Tobacco? Y N If Yes, How much per day?_____

Do You Drink Alcohol? Y N If Yes, How often do you drink?_____

Have You Ever taken any of the following Medications Y N (Please circle)

Risedronate (Actonel)	Pamidronate (Aredia)	Alendronate (Fosamax)
Ibandronate (Boniva)	Etidronate (Didronel)	Zoledronic Acid (Reclast)

Women Only

Are you Currently Pregnant?	Y	N	If Yes, How Far Along_____
Are You Nursing?	Y	N	
Are You Taking Birth Control	Y	N	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medication.

_____ _____ _____

Patient (Print Name) Patient Signature Date

Artistic Smiles Dr. Robert Goldtrap