PATIENT INFORMATION (Confidential)

Patient Name - First _____ Middle _____ Last _____ Sex M___ F___ Birth Date _____
Address _____ Home Phone: _____
City _____ State _____ Zip Code _____
Please circle one: Minor Single Married Divorced Widowed Separated
If Full Time Student, Name of College _____
Relationship to Patient _____
Address, if different _____
Patient or Parent's Employer _____
Work Phone: _____ Cell Phone: _____
Email: _____

If you are a new patient, when was your last dental visit?_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE INFORMATION Family or Single

Name of Insured _____
Relationship to Patient _____
Birth Date _____ Social Security # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Union or Local #_____
Insurance Company Address _____
City _____ State _____ Zip Code _____
Group # _____ Policy ID # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ___ Yes ___ No Family or Single
If yes, complete the following:
Name of Insured _____
Relationship to Patient _____
Birth Date _____ Social Security # _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Union or Local #_____
Insurance Company Address _____
City _____ State _____ Zip Code _____
Group # _____ Policy ID # _____

HIPPA

A copy of Community Dental's Notice of Privacy Practices has been made available.
We may use and disclose health information about you for treatment, payment, and healthcare operations.

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

Signature _____ Date _____

If minor, signature of parent or guardian _____
Relationship to patient _____

OVER

PATIENT MEDICAL-DENTAL HISTORY

Name of Medical Physician/Clinic _____ Phone Number _____

Are you taking any medicines, drugs or pills? Yes or No If yes, please list them:

_____

_____

IMPORTANT: ARE YOU TAKING A BLOOD THINNER? Yes or No
If yes, which medication:

_____

Have you ever taken biphoshomates such as Aredia or Zometa for cancer treatment? Yes or No

Do you have a family history of malignant hyperthermia? Yes or No

Have you ever had or are you being treated for: (PLEASE CIRCLE ALL THAT APPLY)

HEART MURMUR	ASTHMA	VENEREAL DISEASE
HEART TROUBLE/DISEASE	EMPHYSEMA	DIABETES
MITRAL VALVE PROLAPSE	TUBERCULOSIS	KIDNEY DISEASE
JOINT OR VALVE REPLACEMENT	RHEUMATIC FEVER	STOMACH/INTESTINAL DISEASE
HIGH BLOOD PRESSURE	AIDS	DIZZINESS/SEIZURES
JAW JOINT PAIN	HEPATITIS A B C	THYROID PROBLEM
STROKE	BACK PROBLEMS	CANCER

Any surgery within the last five years? _____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Penicillin Latex Local Anesthetics Epinephrine Codeine Aspirin Acrylic Metal

Other Allergies _____

Do you smoke? Yes or No Do you chew tobacco? Yes or No

Are you pregnant or trying to get pregnant? Yes or No If yes, how many months? _____
Are you nursing? Yes or No
Are you taking oral contraceptives? Yes or No

MEDICAL HISTORY CHANGES

Date_____Change _____ Patient _____

Date_____Change _____ Patient _____

Date_____Change _____ Patient _____

Date_____Change _____ Patient _____

Date_____Change _____ Patient _____