

# PATIENT CONFIDENTIAL INFORMATION

**PATIENT:**

NAME: <sup>Mr.</sup> \_\_\_\_\_ <sup>Mrs.</sup> \_\_\_\_\_ <sup>Miss</sup> \_\_\_\_\_ <sup>Dr.</sup> \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
First M.I. Last Month Day Year

NAME THAT YOU WISH TO BE CALLED: \_\_\_\_\_ SCHOOL YOU ARE ATTENDING: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_ HOME PHONE #: (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ MOBILE PHONE #: (\_\_\_\_) \_\_\_\_\_  
Street Apartment

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK PHONE #: (\_\_\_\_) \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_  
First M.I. Last

CHILDREN'S NAMES AND AGES: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ BEST PHONE #: (\_\_\_\_) \_\_\_\_\_  
First M.I. Last

PHYSICIAN NAME: Dr. \_\_\_\_\_ WORK PHONE #: (\_\_\_\_) \_\_\_\_\_  
First M.I. Last

**MEDICAL / DENTAL:** ANSWER EACH ITEM FOR WHICH YOU HAD OR PRESENTLY HAVE. EITHER CIRCLE "YES" OR "NO," OR WRITE IN YOUR RESPONSE.

HEART DISEASE ..... YES NO	HEPATITIS .... (A OR B OR C) ..... YES NO	ORTHODONTIC TREATMENT (I.E. BRACES) ..... YES NO
HEART ATTACK ... WHEN? ..... YES NO	FEN-PHEN OR REDUX USE ..... YES NO	BLEACHING ... (PAST OR PRESENT) ..... YES NO
HEART MURMUR ..... YES NO	SEIZURES .... (GRAND OR PETITE) ..... YES NO	GRINDING OR CLENCHING .. (DAY OR NIGHT) .... YES NO
MITRAL VALVE PROLAPSE ..... YES NO	ARTIFICIAL JOINTS (I.E. HIP OR KNEE) ..... YES NO	JAW POPPING OR CLICKING ..... YES NO
ARTIFICIAL HEART VALVE ..... YES NO	CURRENT PAIN IN MOUTH ..... YES NO	
HEART PACEMAKER ..... YES NO	GAGGING DURING DENTAL TREATMENT ..... YES NO	<i>WOMEN:</i>
HIGH BLOOD PRESSURE ..... YES NO	BLEEDING DURING BRUSHING ..... YES NO	CURRENT PREGNANCY ... MONTH? ..... YES NO
LOW BLOOD PRESSURE ..... YES NO	LOOSENING OF YOUR TEETH ..... YES NO	CURRENTLY NURSING ..... YES NO
RHEUMATIC FEVER ..... YES NO	PERIODONTAL OR GUM DISEASE ..... YES NO	TAKING BIRTH CONTROL MEDICATION .... YES NO
STROKE ... WHEN? ..... YES NO	LIST YOUR DISEASES, CONDITIONS, OR PROBLEMS NOT WRITTEN ABOVE: .....	
DIABETES .... (CHILDHOOD OR ADULT) ..... YES NO	WHEN WAS YOUR LAST MEDICAL EXAMINATION? .....	
TOBACCO USE ... YEARS? ..... YES NO	ARE YOU IN GOOD HEALTH? ..... YES NO	
TUBERCULOSIS ..... YES NO		
CANCER ... TYPE? ..... YES NO		
CHEMOTHERAPY ..... YES NO		
RADIATION THERAPY ..... YES NO		
H.I.V. OR A.R.C. .... YES NO		
BULIMIA ..... YES NO		

CURRENT MEDICATION	DOSE	FREQUENCY	PURPOSE	SINCE

**CIRCLE OR LIST ANY ALLERGIES:**

LATEX    CODEINE    NICKEL

SULFITES (NOT SULFA)    PENICILLIN

OTHER ANTIBIOTIC .....

OTHER MEDICATION .....

WHAT IS YOUR PRESENT DENTAL CONCERN? .....

HOW OFTEN DO YOU FLOSS YOUR TEETH? .....

WHO WAS YOUR PREVIOUS DENTIST? .....

DESCRIBE ANY UNHAPPY DENTAL EXPERIENCES YOU HAD: .....

DO YOU TAKE PREMEDICATION BEFORE DENTAL VISITS? ... TYPE? ..... YES NO

**CONSENT:**

1. TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE.
2. IF I HAVE ANY CHANGES IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DOCTOR AT MY NEXT APPOINTMENT.
3. I GRANT PERMISSION TO THIS OFFICE TO CONTACT MY HEALTHCARE PROVIDERS FOR DETAILS REGARDING ANY OF MY MEDICAL CONDITIONS.
4. COPIES OF THE DENTAL MATERIALS FACT SHEET AND THE NOTICE OF PRIVACY PRACTICES HAVE BEEN PROVIDED TO ME.
5. I PERMIT THIS OFFICE TO TAKE X-RAYS AND TO USE ANY OTHER DIAGNOSTIC AIDS NECESSARY TO EVALUATE MY DENTAL NEEDS.
6. I AUTHORIZE THIS OFFICE TO PERFORM ALL REQUIRED TREATMENT WITH THE APPROPRIATE MEDICATIONS AND THERAPEUTIC AGENTS.

**SIGNATURE OF RESPONSIBLE PARTY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **RELATION TO PATIENT:** \_\_\_\_\_ **OFFICE INITIALS:** \_\_\_\_\_