

# PATIENT INFORMATION for DAVIDSON FAMILY DENTAL

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

Patient's name \_\_\_\_\_ Preferred name \_\_\_\_\_ Birth date \_\_\_\_\_  
If minor, parents names \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_

BILLING, CREDIT, AND INSURANCE INFORMATION:  Not covered by dental insurance  
Your Social Security number: \_\_\_\_\_ Dental Insurance Co. \_\_\_\_\_ Group number \_\_\_\_\_  
Covered by spouse's insurance?  yes  no  
Spouse's dental insurance company \_\_\_\_\_ Group number \_\_\_\_\_  
Spouse's birthday \_\_\_\_\_ 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 use 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 Medication: \_\_\_\_\_

If necessary provide a list of additional medication

Name of your physician: \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Are you taking birthcontrol? \_\_\_\_\_

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

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