## Patient Information

Patient Name _____Date of Birth_____

Address_____Home Phone_____

City, State, Zip Code_____Work Phone_____

Social Security Number_____ Cell Phone_____

Email Address_____

## Individual Information

If you have a family member of relative who is a patient of our practice, please tell us who

Name_____Relationship to Patient_____

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

In case of an emergency, whom should we contact on your behalf?

Name_____Relationship to Patient_____

Address_____ Phone_____

## Dental Insurance Information

| Primary Carrier | Secondary Carrier |
|---|---|
| Insurance Company_____ | Insurance Company_____ |
| Employer_____ | Employer_____ |
| Insured's Name_____ | Insured's Name_____ |
| Insured's Date of Birth_____ | Insured's Date of Birth_____ |
| Insured's Relationship to Patient_____ | Insured's Relationship to Patient_____ |
| Insured's Social Security Number_____ | Insured's Social Security Number_____ |

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dental Implant Institute

Signature of Insured / Employee_____Date_____

## Financial Responsibility

I affirm that the information provided on this form is complete and accurate to the best of my knowledge. I understand I am responsible for the payment of all fees for dental services provided to me (or to the patient named above).

Signature of Patient_____Date_____

(or)

Signature of Parent or Responsible Party_____Date_____

Relationship to Patient_____

Please Complete Other Side

Pharmacy Name_____Address_____Phone_____

**Medical Information and Health History**

Patient Name_____Date of Birth_____

Are you in Good Health? **Yes No**

Are you now under the care of a Physician? **Yes No**

If yes for what condition(s) are you being treated?

_____

Has a Physician or a previous dentist recommended that you take antibiotics prior to dental treatment? **Yes No**

If yes, what antibiotic and dosage?

_____

Have you had any serious illness or operations, Or been hospitalized in the past 3 years **Yes No**

If yes, what was the illness or problem?

_____

_____

Women only:

Are you Pregnant? If yes, _____ months **Yes No**

Could you be pregnant? **Yes No**

Are you Nursing? **Yes No**

Are you taking birth control pills? **Yes No**

Physician: Name _____ Phone_____ Address_____

Are you presently taking any medications or supplements? **Yes No** If yes, please list below. **Do you Smoke? Yes No**

| Name of Medication or Supplement | Dosage and How Often Taken | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you had an allergic or adverse reaction to any medication, anesthetic or other substance? **Yes No** If yes please list below

| Name of Medication or Supplement | Description of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

Indicate which of the following diseases, conditions or problems you have had, or have not had, by checking "Yes" or "No" to each item

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Angina | | | High blood pressure | | | AIDS or HIV Infection | | |
| Arteriosclerosis | | | Low blood pressure | | | Hepatitis or liver disease | | |
| Artificial Heart valves | | | Abnormal bleeding | | | Sexually transmitted disease | | |
| Cardiac stents | | | Anemia | | | Arthritis | | |
| Congenital heart defects | | | Blood transfusion | | | Total joint replacement | | |
| Congestive heart failure | | | Hemophilia | | | Epilepsy | | |
| Coronary artery disease | | | Stroke | | | Fainting spells or seizures | | |
| Damaged heart valves | | | Asthma | | | Severe headaches / migraines | | |
| Heart attack | | | Bronchitis or emphysema | | | Diabetes | | |
| Heart murmur | | | Hay fever / seasonal allergies | | | Gastrointestinal problems | | |
| Mitral valve prolapse | | | Tuberculosis | | | Kidney problems | | |
| Pacemaker | | | Sinus problem | | | Thyroid problems | | |
| Rheumatic heart disease / rheumatic fever | | | Dry Mouth | | | Cancer / chemotherapy radiation treatment | | |
| | | | Mouth sores or ulcers | | | | | |

Do you have or have you had any disease, conditions or problems not listed above? Yes No If yes, please explain _____

_____

I have read and understand the above form, and affirm that the information I have provided is complete and accurate to the best of my knowledge. The information on this form replaces any medical information I have previously provided this office. If I have any changes in my health, medical conditions or medications, I will inform the doctor at the next appointment.

Signature of patient, parent or responsible party_____Date _____