GETTING TO KNOW YOU

DATE: _____

PATIENT NAME _____
(FIRST) (M.I.) (LAST)

DATE OF BIRTH _____ AGE _____

MALE _____ FEMALE _____ OTHER _____ PRONOUNS _____

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____ CHILD _____

HOME ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ PAGER/CELL _____

EMAIL ADDRESS _____ SS# _____

OCCUPATION _____ EMPLOYER _____

FULL TIME STUDENT ☐ YES ☐ NO SCHOOL/COLLEGE _____ CITY _____

GENERAL DENTIST _____ REFERRING DENTIST _____

NEAREST RELATIVE _____ RELATIONSHIP _____

ADDRESS _____ CITY ZIP _____ PHONE _____

NAME OF FAMILY MEMBER WHO HAS BEEN A PATIENT IN OUR OFFICE _____

ACCOUNT INFORMATION
PERSON OR PERSONS FINANCIALLY RESPONSIBLE FOR ACCOUNT

SAME AS ABOVE _____

NAME	NAME
RELATIONSHIP TO PATIENT HOME PHONE	RELATIONSHIP TO PATIENT HOME PHONE
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
BIRTHDATE	BIRTHDATE
MARRIED____ SINGLE_____ DIVORCED_____ WIDOWED_____	MARRIED____ SINGLE_____ DIVORCED_____ WIDOWED_____
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION
BUSINESS ADDRESS	BUSINESS ADDRESS
BUSINESS TELEPHONE	BUSINESS TELEPHONE
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
DRIVERS LICENSE NUMBER	DRIVERS LICENSE NUMBER

PLEASE COMPLETE THE INSURANCE INFORMATION ON THE BACK OF THIS FORM.

INSURANCE INFORMATION

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE COMPANY_____

ADDRESS_____ PHONE #_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

INSURED'S SS # _____/_____/_____ DATE OF BIRTH _____/_____/_____

INSURED'S EMPLOYER _____ GROUP_____

SECONDARY DENTAL INSURANCE COMPANY_____

ADDRESS_____ PHONE #_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

INDURED'S SS # _____/_____/_____ DATE OF BIRTH _____/_____/_____

INSURED'S EMPLOYER _____ GROUP_____

MEDICAL INSURANCE

IF YOU HAVE MEDICAL INSURANCE PLEASE PROVIDE THE FOLLOWING:

PRIMARY MEDICAL INSURANCE COMPANY _____

ADDRESS_____ PHONE #_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

INSURED'S SS # _____/_____/_____ DATE OF BIRTH _____/_____/_____

INSURED'S EMPLOYER _____ GROUP_____

SECONDARY MEDICAL INSURANCE COMPANY _____

ADDRESS_____ PHONE #_____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

INDURED'S SS # _____/_____/_____ DATE OF BIRTH _____/_____/_____

INSURED'S EMPLOYER _____ GROUP_____

I authorize release of information relating to my insurance claims made by this office. I understand that I am responsible for all costs of dental treatment and that this office will bill my insurance as a courtesy to me.

_____ _____

Patient Signature or Parent of a Minor **Date**

Name _____ **DOB** _____

Medical Information *Please mark (X) as your response*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®), Prolia (Denosumab®) or risedronte (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	☐	☐	☐

Date Treatment began: _____

Allergies – Are you allergic or have you had a reaction to: To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐

Other _____

_____

_____

_____

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
COVID-19	☐	☐	☐

Name _____ **DOB** _____

Medical Information *Please mark (X) as your response*

	Yes	No	DK
Do you smoke Marijuana?	☐	☐	☐
If Yes, how often? _____			
Do you use Edibles, THC or CBD Oils?	☐	☐	☐
If Yes, how often? _____			
Do you use controlled substances (drugs)?	☐	☐	☐
Have you ever been addicted to drugs (incl. recreational drugs)	☐	☐	☐
If yes, please list drugs? _____			
Have you ever been in treatment for addiction?	☐	☐	☐
Tobacco (smoking, snuff, chew, e-cigs)?	☐	☐	☐
If so, how much?			
If so, how interested are you in stopping? _____			
(Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
Have you ever had a bad experience in the dental office?	☐	☐	☐
Have you been a patient in the hospital during the past two years?	☐	☐	☐
Have you lost of gained more than 10 pounds in the last year?	☐	☐	☐
Do you ever wake up from sleep short of breath?	☐	☐	☐
Autoimmune disease	☐	☐	☐
Specify: _____			
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
COPD/ Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Has your medical doctor ever said you have cancer or a tumor?	☐	☐	☐
Specify: _____			
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Mastectomy	☐	☐	☐
Side _____			
Lumpectomy	☐	☐	☐
Side _____			
Lymphadenectomy	☐	☐	☐
Side _____			

	Yes	No	DK
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Specify: _____			
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Bruise easily	☐	☐	☐
Liver disease/Yellow jaundice	☐	☐	☐
Hemophilia	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Venereal Disease (Syphilis, Gonorrhea)	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder/Sleep Apnea	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Cold sores	☐	☐	☐
Sickle Cell disease	☐	☐	☐
Hearing aid	☐	☐	☐

WOMEN ONLY Are you:

Pregnant?	☐	☐	☐
Number weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation: _____ Phone: _____			
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐
Please explain:			

Name _____ **DOB** _____

Medical Information *Please mark (X) as your response*

Who is your family doctor? _____

	Yes	No	DK
Are you now under care of a physician for any medical condition?	☐	☐	☐

Physician Name: _____ Phone: Include area code _____

Address/City/State/Zip _____

Do you have Kaiser Medical Coverage?	☐	☐	☐

_____

What is your Kaiser # _____

Which Pharmacy would you like your prescriptions called into?

_____

	Yes	No	DK
Are you in good health?	☐	☐	☐
Recent accident or injuries?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

_____

Date of last physical exam: _____

Height: _____ Weight: _____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what is the illness or problem?

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all including prescription, vitamins natural or herbal medications and/or diet supplements. Please include all medication dosages.

_____

_____

_____

_____

Name _____ DOB _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST/STAFF

Comments: _____