Allendale Dental PATIENT INFORMATION

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Please fill out all the information asked for. Please use NA if the question does not apply. This information will ensure that you are treated efficiently and appropriately.

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Office: _____ Emergency: _____

Email: _____ Who May We Thank for Referring You: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male Social Security #: _____ Drivers Lic. #: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Child Guardians' Name: _____

Patients'/ Guardians' Employer: _____ Office Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Name of the Insurance Company: _____ Name of the Insured: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male Social Security #: _____ Relation to Patient: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medication, pills or drugs? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have taken, Phen-Fen / Redux? ☐ Yes ☐ No _____
Are you on a special diet? ☐ Yes ☐ No _____
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are You ☐ Yes ☐ No Pregnant / Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Asprin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other, please explain: _____

Do you have, or have you had, any of the following? (Circle Y for yes and N for No)

AIDS/HIV Positive: Y • N	Cancer: Y • N	Glaucoma: Y • N	Jaundice: Y • N	Scarlet Fever: Y • N
Alzheimer's: Y • N	Chemotherapy: Y • N	Hay Fever: Y • N	Jaw Problems: Y • N	Shingles: Y • N
Anaphylaxis: Y • N	Chest Pain: Y • N	Heart Attack: Y • N	Kidney Problems: Y • N	Sickle Cell Disease: Y • N
Anemia: Y • N	Cold Sores: Y • N	Heart Murmur: Y • N	Leukemia: Y • N	Sinus Trouble: Y • N
Angina: Y • N	Diabetes: Y • N	Heart Problem: Y • N	Liver Disease: Y • N	Stomach Problems: Y • N
Arthritis/Gout: Y • N	Drug Addiction: Y • N	Hemophilia: Y • N	Low Blood Pressure: Y • N	Stroke: Y • N
Artificial Heart Valve: Y • N	Emphysema: Y • N	Hepatitis A: Y • N	Lung Disease: Y • N	Sudden Weight Loss: Y • N
Artificial Joint: Y • N	Epilepsy: Y • N	Hepatitis B/C: Y • N	Mitral Valve Prolapse: Y • N	Thyroid Disease: Y • N
Asthma: Y • N	Excess Bleeding: Y • N	HPV/Herpes: Y • N	Parathyroid Disease: Y • N	Tuberculosis: Y • N
Blood Disease: Y • N	Fainting/Dizziness: Y • N	High Blood Pressure: Y • N	Radiation Treatment: Y • N	Tumors: Y • N
Blood Transfusion: Y • N	Frequent Cough: Y • N	Hives/Rash: Y • N	Renal Dialysis: Y • N	Ulcers: Y • N
Breathing Problem: Y • N	Frequent Diarrhea: Y • N	Hypoglycemia: Y • N	Rheumatic Fever: Y • N	Venereal Disease: Y • N
Bruise Easily: Y • N	Frequent Headaches: Y • N	Irregular Heart Beat: Y • N	Rheumatism: Y • N	Other: Y • N

Have you had any other illnesses? If yes, please explain:

Name of Previous Dentist: _____ **Phone:** _____ **Date of last checkup:** _____ **X-Rays:** _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____