HEATHMAN FAMILY & COSMETIC DENTISTRY

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 __________ Cell phone __________Work phone__________

Mailing address ______________________________ City ________________State ______ Zip _________

Employer ________________________ Occupation ______________________________

Email ______________________ Emergency Contact______________________________

Whom may we thank for referring you to our office? ______________________________ ❑ Phonebook

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 name__________________ Employer________________

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)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint or valve DATE:______________
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Diabetes
- ❑ Emotional condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Hayfever or sinus trouble
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Low blood pressure
- ❑ Migraine headaches or frequent headaches
- ❑ Neurologic condition
- ❑ Pacemaker
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Tuberculosis or other lung problems
- ❑ NONE

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics
- ❑ Latex materials
- ❑ Local anesthetics ("Novocain")
- ❑ Other:______________________________
- ❑ Penicillin or other antibiotics ________________
- ❑ Sulfa drugs
- ❑ NONE

Please list ALL the medications you are taking:

____
____
____
____
____

Do you have any other conditions, disease or problems not listed above? ______________________
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Women:

- ❑ May be pregnant
  Expected delivery date: ___________
- ❑ Taking hormones or contraceptives

Name of your physician:________________________________Phone #:______________________Please

add anything else you would like us to know about:____

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Signature of patient (or parent) ______________________________ Date

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