Patient Information
Dr. Hall

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name:_____ Date of Birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email :_____

SS #: _____ Employer/ Occupation: _____ Bus. Phone: _____

Spouse's name & phone: _____ Emergency phone #: _____

Primary dental insurance : _____ Group #: _____

Second dental insurance: _____ Group #: _____

Subscriber's name: _____ Birth date: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Medical Health History:
Do you, or have you had, any of the following?

Heart Problems

Chest pain ---------- yes no
Shortness of breath ---------- yes no
Blood pressure problem s------ yes no
Heart murmur ---------- yes no
Heart valve problem ---------- yes no
Taking heart medication ------- yes no
Rheumatic fever ---------- yes no
Pacemaker ---------- yes no
Artificial heart valve ---------- yes no

Blood Problems

Easy bruising ---------- yes no
Frequent nosebleeds ---------- yes no
Abnormal bleeding ---------- yes no
Blood disease (anemia) ---------- yes no
Required a blood transfusion --- yes no

Allergy Problems

Hay fever ---------- yes no
Sinus problems ---------- yes no
Skin rashes ---------- yes no
Taking allergy medication -------- yes no
Asthma ---------- yes no

Intestinal Problems

Ulcers ---------- yes no
Weight gain or loss ---------- yes no
Special diet ---------- yes no
Constipation/Diarrhea ---------- yes no
Kidney or bladder problems ----- yes no

Bone or Joint Problems

Arthritis ---------- yes no
Back or neck pain ---------- yes no
Joint replacement ---------- yes no
(eg hip, pins, implants)

Fainting spells, Seizures, Epilepsy ---------- yes no
Stroke ---------- yes no
Frequent severe headaches ---------- yes no
Thyroid problems ---------- yes no
Persistent cough, or swollen glands ---------- yes no
Premedications required by doctor ---------- yes no
Cancer/ turmors ---------- yes no

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

Local anesthetics (novocaine) ---------- yes no
Penecillin or other antibiotics ---------- yes no
Sulfa drugs ---------- yes no
Barbiturates, sedatives, or sleeping pills ------- yes no
Asprin, Acetaminophen, or Ibuprofen ---------- yes no
Reaction to metals ---------- yes no
Latex or rubber ---------- yes no
Other: _____

Diabetes

Urinate more than 6 times per day ---------- yes no
Thirsty or mouth is dry much of the time -------- yes no
Family history of diabetes

Tuberculosis or other respiratory disease? ---------- yes no
Do you drink alcohol, how much? ---------- yes no
Do you smoke? How much? ---------- yes no
Hepatitis, jaundice, liver trouble ---------- yes no
Herpes or other STD---------- yes no
HIV -positive/ AIDS ---------- yes no
Glaucoma ---------- yes no
Do you wear contact lenses? ---------- yes no
History of head injury? ---------- yes no
Epilepsy or other neurological disease? ---------- yes no
History of alcohol or drug abuse? ---------- yes no

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
Please describe:

_____

_____

During the past 12 months, have you taken any of the following:

Antibiotics or sulfa drugs ---------- yes no
Anticoagulants (eg coumadin) ---------- yes no
High blood pressure medicine ---------- yes no
Tranquilizers ---------- yes no
Insulin, Orinase, or similar drug ---------- yes no
Aspirin ---------- yes no
Digitalis or drugs for heart trouble ---------- yes no
Nitroglycerin ---------- yes no
Cortisone (steroids) ---------- yes no
Natural remedies ---------- yes no
Nonperscription drugs/ supplements ---------- yes no
Other:_____

_____

Women

Are you taking contraceptives or other hormones? -------- yes no
Are you pregnant? If so, expected delivery date? ---------- yes no

_____

Are you nursing? ---------- yes no
Have you reached menopause? If so, do you have any symptoms?

_____

_____

Patient/Parent Signature:

_____

Dentist Initial:

_____