The Art of Dentistry

Personal Information Form

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home # _____

Employer: _____ Occupation: _____ Cell # _____

Spouse: _____ Spouse # _____

Referred by: _____ Physician: _____ Phone # _____

Emergency Contact: _____ Phone # _____

Insurance Information

Dental Insurance 1: _____	Dental Insurance 2: _____
Name of Insured: _____	Name of Insured: _____
Policy# _____ Cert Plan# _____	Policy# _____ Cert Plan# _____
Coverage % 0% 0% 0% 0% Division: _____ (A B C D)	Coverage % 0% 0% 0% 0% Division: _____ (A B C D)
Sin# _____	Sin# _____
Care Card# _____	Care Card# _____
Limits: _____ _____ (Basic Major) Deductible: _____ (Person/Family)	Limits: _____ _____ (Basic Major) Deductible: _____ (Person/Family)
Scaling Limit: _____	Scaling Limit: _____

Medical History

		Yes	No
1.	Are you under a physician's care?	☐	☐
2.	Have you ever been a patient in a hospital?	☐	☐
3.	Are you taking any prescription or over the counter medication?	☐	☐
4.	Have you ever taken Cortisone or steroid medication?	☐	☐
5.	Do you bruise easily or bleed excessively?	☐	☐

6. Are you allergic to any of the following? (Check those which apply)

☐ Local Anesthetics ☐ Penicillin ☐ Other Antibiotics

☐ Codeine ☐ Aspirin ☐ Other Drugs (Please specify)

7. Have you had any of the following conditions? (Please check those that apply)

☐ High Blood Pressure ☐ Tuberculosis ☐ Asthma ☐ Ulcer

☐ Heart Trouble ☐ Rheumatic Fever ☐ Heart Murmur ☐ Diabetes

☐ Liver Disease (Hepatitis) ☐ HIV ☐ Glaucoma ☐ Kidney Disease

☐ Nervous Disorder ☐ Cancer ☐ Epilepsy ☐ Radio/Chemotherapy

☐ Bone /Muscle /Joint Disorders (e.g. Arthritis) ☐ Hormonal Disorder (e.g. Thyroid) ☐ Artificial Joints or Valves

8. Do you have any other conditions that the dentist should be aware of which could influence dental ltreatment?