Patient Information Form

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 # (other than spouse)_____

Primary Dental Insurance:_____ Group #:_____

Secondary Dental Insurance:_____ Group #:_____

Subscriber's Name:_____Date of Birth:_____ SS#:_____

Name of Patient's Medical Doctor:_____ Date of Last Visit To Medical Doctor:_____

Name of Previous Dentist:_____ Date of Last Visit To Dentist:_____

How Did Hear About North Creek Dental Care? _____

Dental and Medical Health History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Any problems with previous dental treatment?	☐	☐
Satisfied with the appearance of your teeth?	☐	☐
Does your jaw make noise so that it bothers you?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do you have, or have you had, any of the following?		
Heart problems	☐	☐
Chest pain	☐	☐
Blood pressure problem	☐	☐
Taking heart medication	☐	☐
Pacemaker	☐	☐
Blood Problems	☐	☐
Easy Bruising	☐	☐
Fainting Spells, Seizures	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Cancer/tumor	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g. total hip, pins, implants)	☐	☐
Do you smoke?	☐	☐

If yes, how much?_____

	Yes	No
Diabetes	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Pre-medications required by physician	☐	☐
Do you have any allergies to medication	☐	☐
Are you allergic to Latex or rubber dam	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
History of head injury	☐	☐
Epilepsy or other neurological disease	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐

If yes, then which medications?_____

_____

If yes, please describe:_____

What medications have you taken in the past 12 months?

_____

_____

Are you pregnant?_____ **If yes, expected due date:**_____

Are you nursing?_____

Notes:_____

_____

Patient/Parent Signature:_____

Dentist Initial:_____ Date:_____