Patient Information Form

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____ Pronouns: _____

Home Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

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

Spouse's Name & Phone #: _____ Emergency Phone # (other than spouse): _____

Primary Dental Ins: _____Subscriber Name & DOB: _____ Subscriber ID: _____

Secondary Dental Ins: _____ Subscriber Name & DOB: _____ Subscriber ID: _____

Patient's Medical Doctor: _____ Date of Last Visit to Medical Doctor: _____

Patient's Previous Dentist: _____ Date of Last Visit to Dentist: _____

How Did You Hear About North Creek Dental Care? _____

Dental and Medical 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? ----	☐	☐
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 ----------	☐	☐
Endocarditis ----------	☐	☐
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 ----------	☐	☐
Do you smoke/vape? ____If yes, how much? _____	☐	☐
Have you ever taken Bisphosphonate (Fasomax)?	☐	☐

	Yes	No
Diabetes ----------	☐	☐
Thirsty or mouth is dry much of the time ----	☐	☐
Family history of diabetes ----------	☐	☐
Pre-medications required by physician ----------	☐	☐
Do you have or have had tuberculosis? ----------	☐	☐
Do you have sleep apnea or symptoms of sleep apnea?	☐	☐
Do you have any allergies to medication ----------	☐	☐
If yes, then which medications? _____		
_____		
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		
that you feel we should know about? ----------	☐	☐

Medications you have taken in the past twelve months:

_____

_____

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

Are you nursing? _____

Notes: _____

_____

Patient (or Guardian) Signature: _____

Dentist Initial: _____ Date: _____