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 & #: _____ Emergency Contact (name & #): _____

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 click, pop, or cause pain? ----------	☐	☐
You clench or grind your jaws frequently? ----------	☐	☐
Do you have, or have you had, any of the following?		
Heart Problems: _____	☐	☐
History of heart attack? When: _____	☐	☐
Chest Pain ----------	☐	☐
Blood Pressure Problem ----------	☐	☐
Taking heart medication ----------	☐	☐
Pacemaker ----------	☐	☐
Endocarditis ----------	☐	☐
Blood Problems ----------	☐	☐
Easy Bruising ----------	☐	☐
Fainting Spells, Seizures, Epilepsy ----------	☐	☐
Stroke(s) ----------	☐	☐
Frequent or Severe Headaches ----------	☐	☐
Thyroid Problems ----------	☐	☐
Cancer/Tumor ----------	☐	☐
Bone or Joint Problems ----------	☐	☐
Arthritis or Osteoporosis ----------	☐	☐
Back or Neck Pain ----------	☐	☐
Joint Replacement _____	☐	☐
Do you smoke/vape? ____ If yes, how much? _____	☐	☐
Have you ever taken Bisphosphonate, Fosamax, Boniva,		
Actonel, or Aredia? ----------	☐	☐

	Yes	No
Have you taken Suboxone, Buprenorphine or Naloxone?	☐	☐
Diabetes ----------	☐	☐
Thirsty or mouth is dry much of the time ----	☐	☐
Are you Insulin dependent ----------	☐	☐
Pre-medications required by physicians _____	☐	☐
Do you have or have you 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 or neck injury----------	☐	☐
History of alcohol or drug abuse? ----------	☐	☐

Do you have any diseases, conditions or problems not listed that you feel we should know about?

_____

Medications have you 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: _____