# Welcome to the Dental Dimensions Family

## PATIENT INFORMATION

**Referred By:**_____

Patient Name: _____ Preferred Name_____
Last First MI

☐ Male ☐Female ☐Married ☐Single ☐Child ☐Other_____ Social Security #: _____

Birth Date:_____Age:_____ Email Address:_____

Phone (Home): _____ (Work): _____ Cell:_____ Best time to call: _____

Spouse's Name(or parent of child): _____Social Security #: _____Birth Date:_____
Last First

Would you prefer your appointment reminders sent by: Email or Text Message? (Please circle one)

Address: _____
Street Apartment

_____
City State Zip Code

Employer_____Occupation_____

Employer Address_____

Name, Address, Phone Number of nearest relative not living with you_____

## HEALTH INFORMATION

• Have you been under the care of a physician in the past 2 years? ☐ Yes ☐ No B/P_____

If yes, please explain:_____

• Name of Physician: _____ Phone:_____

• Are you taking any prescription, non-prescription or homeopathic medication, drugs, vitamin supplements or pills: ☐ Yes ☐ No

If yes, please list name and dosage_____

• Have you taken oral or intravenous bisphonate therapy(fosamax, actonel, boniva, skelid, didronel, aredia, zometa, bonefos)for osteoporosis or cancer:☐ Yes☐ No

If yes, please list name, when taken, and dosage_____

• Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
Check appropriate boxes: ☐ Local Anesthetics ☐ Aspirin ☐ Sedatives ☐ Penicillin or other antibiotic ☐ Codeine or other narcotics
Other_____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:_____

• Have you ever been told you need antibiotic premedication prior to dental procedures? ☐ Yes ☐ No
If yes, why and what antibiotic was recommended?_____

• Women: Are you: **Pregnant?** ☐ Yes, for _____months ☐ No **Nursing?** ☐ Yes ☐ No **Take Birth Control Pills?** ☐ Yes ☐ No

• Do you: Smoke or chew tobaccco? ☐ Yes ☐ No Eat a balanced diet? ☐ Yes ☐ No Maintain adequate water intake daily ☐ Yes ☐ No
Exercise ☐ Yes ☐ No

**Have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ☐ Abnormal Bleeding | ☐ Chest Pain | ☐ Hemophilia | ☐ Respiratory Problems |
| ☐ AIDS or HIV Positive | ☐ Circulatory Problems | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Alcoholism | ☐ Cold Sores | ☐ High Blood Pressure | ☐ Sickle Cell Anemia |
| ☐ Allergies | ☐ Diabetes | ☐ Jaundice | ☐ Sinus Problems |
| ☐ Anemia | ☐ Drug Abuse | ☐ Kidney Disease | ☐ Stomach Problems |
| ☐ Arthritis | ☐ Epilepsy/Seizures | ☐ Latex Allergy | ☐ Stroke |
| ☐ Artificial Joints | ☐ Fainting/Dizzy Spells | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Artificial Heart Valve | ☐ Glaucoma | ☐ Osteoporosis | ☐ Tuberculosis |
| ☐ Asthma | ☐ Head Injuries | ☐ Pacemaker | ☐ Ulcers |
| ☐ Blood Disease | ☐ Heart Disease | ☐ Psychological Disorder | ☐ Sexually Transmitted Disease (active) |
| ☐ Bruise Easily | ☐ Heart Murmur | ☐ Radiation Treatment | |

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

_____ Date:_____
Signature of patient, parent or guardian

_____Date:_____
Provider Signature

Updated:_____ _____ _____ _____ _____