

Confidential Patient Information

PATIENT:

Date _____

Name _____
Last First Middle

Home Phone _____

Address _____
City State Zip

Place of Employment _____ Occupation _____

Work Address _____
City State Zip

Work Phone _____

Email Address _____

Cell Phone _____

Date of Birth _____ SS# _____ Male _____ Female _____

Height ____ ft. ____ in. Weight ____ # Marital Status: Single Married Divorced Widowed

Hobbies _____

SPOUSE:

Name _____
Address if different from above

Place of Employment _____ Occupation _____

Work Address _____
City State Zip

Work Phone _____

Person Responsible for Account _____

Whom may we thank for referring you to our office? _____
Address if different from above

Has any member of your family been treated in our office previously? Yes No Relationship _____

Why did you choose Worcester Dental? _____

Reason for Visit _____

DENTAL HEALTH:

Please check one: Excellent Good Fair Poor

What priority do you give your teeth (10 being the highest)?

DENTAL INSURANCE:

PRIMARY Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

SECONDARY Carrier Insurance Company _____

Mailing Address _____

Employee _____ SS# _____ Group # _____

MEDICAL HEALTH: Please check one: Excellent Good Fair Poor

Physician's Name _____

Date of last complete physical _____ Are you under a doctor's care now? _____ If yes, for what reason?

Please list any medications, pills or drugs you are taking _____

Please list any vitamins or herbs you are taking _____

Have you ever received a blood transfusion? Yes No When? _____

Are you pregnant? _____ How long? _____

Are you subject to prolonged bleeding? Yes No Do you smoke? _____ How many packs per day? _____

Soda consumption per day _____ Candy consumption per day _____

Are you allergic to : Penicillin Codeine Local Anesthetics Other medications - list below

Please check if you have or have had any of the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> X-Ray or Cobalt Therapy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chemotherapy/Radiation |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Feet/Ankles/Hands | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A (infectious) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints/Hips | <input type="checkbox"/> Hepatitis B (serum) | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> AIDS |

Have you ever had any other serious illness not checked above? Yes No If yes, please describe in detail:

If you are at Worcester Dental regarding dentures, please provide the following:

Are you currently wearing dentures/partials? Yes No If yes, for how many years? _____

How old is your present dentures/partials? _____

Where did you last purchase your dentures/partials? _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date _____ Patient Signature _____