MINOR PATIENT INFORMATION

PATIENT Legal Name _____ _____
First Mid. Initial Last Nickname

Date of Birth_____ Male___ Female___ Whom may we thank for referring you? _____

ACCOMPANYING PARENT/GUARDIAN: _____ _____
First Mid. Initial Last Nickname

Relationship to patient_____ Date of Birth_____ Male___ Female___ Emergency Contact? Yes No

Mailing Address _____
Street/ P.O. Box Unit # City State Zip

Cell Phone_____Work Phone_____Home Phone_____

S.S. #_____ Check appropriate space: Single__ Married__ Divorced__ Separated__ Widowed__ Domestic Partner__

E-mail

Employer (company/city) _____

FINANCIALLY RESPONSIBLE (if different): _____ _____
First Name Mid. Initial Last Name Nickname

Relationship to patient_____ Date of Birth_____ Male___ Female___ Emergency Contact? Yes No

Mailing Address _____
Street/ P.O. Box Unit # City State Zip

Cell Phone_____Work Phone_____Home Phone_____

S.S. #_____ Check appropriate space: Single__ Married__ Divorced__ Separated__ Widowed__ Domestic Partner__

E-mail

Employer (company/city) _____

PRIMARY DENTAL INSURANCE: Insurance Co._____

Claim Mail Addr._____

Group (employer name, "Self", etc.) _____ Group # _____

Subscriber _____ Relationship to Patient _____ Date of Birth _____

Mail Address (if different from above) _____
Street/ P.O. Box Unit # City State Zip

S.S. # _____ ID# _____ Day Phone _____

Is the patient covered by additional dental insurance? YES _____ NO _____ - IF YES, PLEASE COMPLETE THIS SECTION:

SECONDARY DENTAL INSURANCE: Insurance Co._____

Claim Mail Addr._____

Group (employer name, "Self", etc.) _____ Group # _____

Subscriber _____ Relationship to Patient _____ Date of Birth _____

Mail Address (if different from above) _____
Street/ P.O. Box Unit # City State Zip

S.S. # _____ ID# _____ Day Phone _____

IF DENTAL INSURANCE APPLIES: Although this office files insurance claims as a service to our patients, the insurance contract is between the subscriber & insurance company. As we have no control over the insurance company's processing policies or amount of payment, any amount not paid by insurance, is entirely the responsibility of the patient. INITIALS: _____

OVER →

MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Have you ever had an **ALLERGIC or ADVERSE REACTION to LATEX**? Reaction:_____ **Yes** **No**
2. Are you currently under your medical doctor's care for a current medical problem? ..... **Yes** **No**
   Reason:_____
3. Have you been hospitalized in the past five years? ..... **Yes** **No**
   Reason: _____
4. Are you required to take premeds prior to dental treatment? WHY?_____ **Yes** **No**
5. Have you received therapy for alcoholism or drug addiction during the past five years? ..... **Yes** **No**
6. Have you ever had any **ALLERGIC or ADVERSE REACTIONS to anesthetics**, antibiotics, or other medications? Please explain and the reaction it causes:_____ **Yes** **No**
7. Have you ever required a blood transfusion? Please explain:_____ **Yes** **No**
8. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? ..... **Yes** **No**
9. Do you smoke, snuff, chew, or use canabis?..... **Yes** **No**
10. Are you taking or scheduled to begin taking either of the medications? Alendroate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's disease? ..... **Yes** **No**
11. List any medications you are currently taking:
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____

12. **Do you or have you ever had any of the following (please check):**

____ Joint replacement Pre-Med? **Y / N**
____ Angina pectoris
____ Thyroid problems
____ Asthma Controlled? **Y / N**
Last Albuterol _____

____ Hepatitis
____ Difficult breathing
____ Frequent headaches
____ Emphysema
____ Lung disease
____ Psychiatric problems
____ Diabetes
Last BG Level ____
Controlled? **Y / N**

____ Blood disorders:
____ Sickle cell disease
____ Anemia
____ Abnormal bleeding

____ High blood pressure- Controlled? **Y / N**
____ Active tuberculosis
____ Venereal diseases
____ Stroke Controlled? **Y / N**
Last episode_____

____ Cancer/chemotherapy
____ Fever blisters
____ Sinus problems
____ Liver disease
____ HIV/AIDS
____ Kidney problems
____ Seizures
Last episode_____
Controlled? **Y / N**

____ Heart Conditions: Pre-Med? **Y / N** Controlled? **Y / N**
____Heart murmur of prolapsed valve MVP
____ Pacemaker
____ Artificial heart valves
____ Congenital heart defects

WOMEN ONLY- Are you: Pregnant? **Yes / No** If yes, number of weeks? _____ Nursing? **Yes** **No**
Taking birth control pills or hormonal replacement? **Yes** **No**

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Patient/Legal Guardian: _____ Date: _____

HIPAA ACKNOWLEDGEMENT AND RECEIPT OF NOTICE

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

**YOU MAY REFUSE TO SIGN THIS ACKOWLEDGEMENT. PATIENT REFUSED TO SIGN HIPAA _____