



PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Street Address: _____ Preferred Phone: _____

City: _____ State: _____ ZIP: _____

Cell: _____ Email: _____ SSN: _____

Emergency Contact - Name and Phone: _____

Race: ☐ African American ☐ Asian ☐ White ☐ Hispanic ☐ Other: _____

Family Physician: _____ City: _____ State: _____

Preferred Pharmacy: _____ Phone: _____ Address: _____

VISIT DETAILS

Reason for today's visit: _____

Have you been treated here before? ☐ YES ☐ NO If yes, when: _____

How did you hear about us?

☐ Magazine ☐ Newspaper ☐ Radio ☐ Billboard ☐ Mail ☐ TV
☐ Friend / Family ☐ Internet ☐ Doctor ☐ Agency ☐ Other: _____

Signature: _____ Date: _____

DENTAL INSURANCE / DENTAL HISTORY

Dental Insurance Provider: _____

Current cardholder? ☐ YES ☐ NO

Currently wear dentures? ☐ YES ☐ NO If yes, how long: _____

Previous tooth extraction? ☐ YES ☐ NO What: _____



MEDICAL HISTORY QUESTIONS

Patient Name: _____ Date of Birth: _____

Check Yes or No. Explain every 'Yes' answer on the line provided.

☐ YES	☐ NO	Cancer, chemotherapy, or radiation therapy? Explain: _____
☐ YES	☐ NO	Heart attack, chest pain, heart failure, pacemaker, or arrhythmia? Explain: _____
☐ YES	☐ NO	Heart murmur, valve replacement, or need for antibiotic premedication? Explain: _____
☐ YES	☐ NO	High or low blood pressure? Explain: _____
☐ YES	☐ NO	Asthma, COPD, sleep apnea, or another breathing problem? Explain: _____
☐ YES	☐ NO	Diabetes or another endocrine condition? Explain: _____
☐ YES	☐ NO	Knee, hip, or other joint replacement? Explain: _____
☐ YES	☐ NO	Seizures, epilepsy, stroke, or another neurologic condition? Explain: _____
☐ YES	☐ NO	Renal (kidney) disease or dialysis? Explain: _____
☐ YES	☐ NO	Liver disease, hepatitis, or cirrhosis? Explain: _____
☐ YES	☐ NO	Anemia, bleeding disorder, or daily blood thinner use? Explain: _____
☐ YES	☐ NO	HIV, immune disorder, or serious infectious disease? Explain: _____
☐ YES	☐ NO	Allergy to latex, penicillin, anesthetic, or another medication? Explain: _____
☐ YES	☐ NO	Osteoporosis or bisphosphonate / Prolia use? Explain: _____
☐ YES	☐ NO	Any other serious health condition, hospitalization, or surgery? Explain: _____

Patient Signature: _____ Date: _____

MEDICAL CONDITIONS

Check every condition that applies

HEART / BLOOD PRESSURE

- ☐ Rheumatic fever / heart disease
- ☐ Infective endocarditis
- ☐ Artificial heart valve
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina / chest pain
- ☐ Heart attack - Date: ____
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Arrhythmia
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Other: ____

RESPIRATORY / LUNG

- ☐ Asthma
- ☐ Emphysema / COPD
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Other: ____

CANCER / TUMORS

- ☐ Malignant - Location: ____
- ☐ Benign - Location: ____

KIDNEY / URINARY

- ☐ Renal failure / insufficiency
- ☐ Dialysis
- ☐ Frequent urination
- ☐ Other: ____

DIABETES / ENDOCRINE

- ☐ Diabetes - Type 1 / Type 2
- ☐ Thyroid problems
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other: ____

NEUROLOGIC / MENTAL HEALTH

- ☐ Stroke / TIA - Date: ____
- ☐ Seizures / epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson disease
- ☐ Neuropathy
- ☐ Dementia / Alzheimer disease
- ☐ Headaches
- ☐ Fainting / dizzy spells
- ☐ Tingling or numbness
- ☐ Bipolar / manic depression
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADD / ADHD
- ☐ Anxiety
- ☐ Other: ____

BLOOD / HEMATOLOGIC

- ☐ Anemia
- ☐ Sickle cell disease / trait
- ☐ Bruise easily
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding disorder
- ☐ Hemophilia
- ☐ Other: ____

STOMACH / INTESTINE / LIVER

- ☐ Cirrhosis / chronic hepatitis
- ☐ Jaundice
- ☐ Hepatitis A / B / C / D / Other
- ☐ Heartburn / acid reflux
- ☐ Ulcers
- ☐ Crohn disease
- ☐ Other: ____

MUSCLE / BONE / CONNECTIVE

- ☐ Joint replacement
- ☐ Arthritis / rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ TMJ disorder
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Other: ____

INFECTIOUS DISEASE

- ☐ HIV / AIDS
- ☐ STD
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Human papillomavirus
- ☐ Cold sores
- ☐ Other: ____

HEAD / EYES / EARS / NOSE / THROAT

- ☐ Vision problems
- ☐ Glaucoma
- ☐ Hearing impairment
- ☐ Other: ____

SKIN / EATING / OTHER

- ☐ Skin condition: ____
- ☐ Bulimia
- ☐ Anorexia
- ☐ Other condition: ____

Is a medical consultation necessary?

☐ YES

☐ NO

Patient Signature: _____

Date: _____

MEDICAL HISTORY

Medications, allergies, and health habits

Have you taken, are you taking, or are you scheduled to begin osteoporosis medication?

- ☐ Oral bisphosphonates (Fosamax, Boniva, Actonel, or similar)
☐ Intravenous bisphosphonates (Aredia, Reclast, Zometa, or similar)
☐ Prolia (Denosumab)

TOBACCO / ALCOHOL

Use or previously used tobacco?

- ☐ Smoking - Past / Current
☐ Snuff - Past / Current
☐ Chew - Past / Current
☐ Bidis - Past / Current
☐ Vaping - Past / Current

Drink alcoholic beverages?

- ☐ YES ☐ NO ☐ DK

Alcohol dependent?

- ☐ YES ☐ NO ☐ DK

RECREATIONAL SUBSTANCES

Use or previously used recreational substances?

- ☐ Cocaine - Past / Current
☐ Ecstasy - Past / Current
☐ Heroin - Past / Current
☐ Marijuana - Past / Current
☐ Methamphetamine - Past / Current
☐ Oxycontin - Past / Current
☐ Other: _____ Past / Current

Drug dependent?

- ☐ YES ☐ NO ☐ DK

FEMALE PATIENTS

Pregnant?

- ☐ YES ☐ NO ☐ DK

Nursing?

- ☐ YES ☐ NO ☐ DK

Taking birth control, fertility drugs, or hormones?

- ☐ YES ☐ NO ☐ DK

ALLERGIES

- ☐ Local anesthetics
☐ Penicillin
☐ Sulfa drugs
☐ Aspirin
☐ Codeine / narcotics
☐ Hay fever / seasonal
☐ Metals / jewelry
☐ Iodine
☐ Latex
☐ Food / other: _____
☐ No known allergies

MEDICATIONS AND SUPPLEMENTS

List all prescription medicines, over-the-counter medicines, vitamins, supplements, natural products, and herbal products. Include dosage and frequency.

Medication / Supplement	Dosage	Frequency

Daily blood thinner, including aspirin?

- ☐ YES ☐ NO ☐ DON'T KNOW

If yes: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement. For more information, please contact our Privacy Officer.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here: _____

Signature: _____ Date: _____

We generally cannot discuss your protected health information (PHI) with anyone other than you unless you authorize us. List the individual(s) you authorize our office to discuss your care with. This authorization remains in effect until you notify us otherwise in writing.

Relationship: _____ Name: _____

Relationship: _____ Name: _____

Relationship: _____ Name: _____

OFFICE USE ONLY

Written acknowledgement could not be obtained because:

- ☐ The patient refused to sign.
- ☐ An emergency prevented acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please specify):

Employee Signature: _____ Date: _____