

# Confidential Patient Information

Date \_\_\_\_\_

**PATIENT:** Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
City State Zip

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City State Zip

Email address: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Height \_\_\_\_\_ ft \_\_\_\_\_ in Weight \_\_\_\_\_ # Marital Status: Single  Married  Divorced  Widowed

Hobbies: \_\_\_\_\_

**SPOUSE:** Name \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_  
Address if different from above

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City State Zip

Person Responsible for Account \_\_\_\_\_  
Address if different from above

*A finance charge of 18% per year will be added to any account that is delinquent.*

Whom may we thank for referring you to our office? \_\_\_\_\_

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

Why did you choose Dr. Baker as your dentist? \_\_\_\_\_

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 # \_\_\_\_\_

*Please complete other side*

**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 CLICK 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 Treatment |
| <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      |  |

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

*I will allow Dr. Baker to photograph/videotape and use for educational purposes any aspect of my dental conditions or treatment procedures, and to publish any testimonials I provide. I further permit him to discuss my conditions with my physician and to request medical information from him.*

**Patient's Signature** \_\_\_\_\_

### MEDICAL UPDATES:

*I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.*

Date	Exceptions	Patient's Signature	Reviewed By
_____	_____ None <input type="checkbox"/>	_____	_____
_____	_____ None <input type="checkbox"/>	_____	_____
_____	_____ None <input type="checkbox"/>	_____	_____