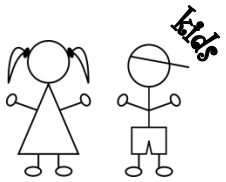
PRIME Dental Group



PATIENT INFORMATION **Today's Date: ____/_____/_____**

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female Social Security #: _____

Phone (Home): _____ Cell_____ Birth Date _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Preferred Appointment Confirmation Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Preferred Method to Schedule Appointments: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text

Home address: _____
Street City/State Zip Code

Please list other members of your immediate family who are patients in our office
_____

Can we thank someone for referring you?	**Or did you find us on your own?**
Family Member_____	___Website
Coworker_____	___Social Media ___Lumineer
Friend _____	___Insurance Company ___Walk in
Doctor _____	___Post Card ___Other

What is the reason for your visit today? _____
_____

Date of Last Dental Visit: _____
Do you prefer Nitrous Oxide (laughing gas) during dental procedure? ☐ Yes ☐ No

Dental Insurance

Primary Insurance Information

Name: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child
Insured SSN: _____ Insured DOB____/____/_____
Employer: _____ Insurance Name: _____
Address: _____ Member ID: _____
City, State, Zip: _____ Group Number: _____

Name of person completing form _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential.

***PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year?……..…Y N
3. Date of last check up by physician ____/____/____
4. Are you currently in a physician's care? .....Y N

If so, what for? _____

Treating Physician's Name: _____ Phone Number: _____

5. Have you had any serious illness, operations, or hospitalizations? ……Y N

If so, describe and give approximate dates: _____

_____

6. Have you ever had intravenous sedation or general anesthesia……..Y N
   Were there any adverse effects? ……Y N
7. Do you generally tolerate dental treatment well? ……...Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

- AIDS/HIV Positive Y N
- Anaphylaxis Y N
- Anemia Y N
- Angina Y N
- Arthritis/Gout Y N
- Artificial Heart Valve Y N
- Artificial Joint Y N
- Asthma Y N
- Blood Disease Y N
- Blood Transfusion Y N
- Breathing Problems Y N
- Bruise Easily Y N
- Cancer Y N
- Chemotherapy Y N
- Chest Pain Y N
- Cold Sores/Fever Blisters Y N
- Congenital Heart Disorder Y N
- Convulsions Y N
- Cortisone Medicine Y N
- Diabetes Y N
- Drug Addiction Y N
- Easily Winded Y N
- Emphysema Y N
- Epilepsy or Seizures Y N
- Excessive Bleeding Y N
- Excessive Thirst Y N
- Fainting Spells/Dizziness Y N
- Frequent Cough Y N
- Frequent Diarrhea Y N
- Frequent Headaches Y N
- Genital Herpes Y N
- Glaucoma Y N
- Hay Fever Y N
- Heart Attack/Failure Y N
- Heart Murmur Y N
- Heart Pacemaker Y N
- Heart Trouble/Disease Y N
- Hemophilia Y N
- Hepatitis A Y N
- Hepatitis B or C Y N
- Herpes Y N
- High Blood Pressure Y N
- High Cholesterol Y N
- Hives or Rash Y N
- Hypoglycemia Y N
- Irregular Heartbeat Y N
- Kidney Problems Y N
- Leukemia Y N
- Liver Disease Y N
- Low Blood Pressure Y N
- Lung Disease Y N
- Mitral Valve Prolepses Y N
- Osteoporosis Y N
- Pain in Jaw Joints Y N
- Parathyroid Disease Y N
- Psychiatric Care Y N
- Radiation Treatment Y N
- Renal Dialysis Y N
- Rheumatic Fever Y N
- Shingles Y N
- Sickle Cell Disease Y N
- Sinus Trouble Y N
- Spinal Bifida Y N
- Stomach Disease Y N
- Stroke Y N
- Swelling of Limbs Y N
- Thyroid Disease Y N
- Tonsillitis Y N
- Tuberculosis Y N
- Tumors or Growths Y N
- Ulcers Y N
- Yellow Jaundice Y N

ARE, YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- Local anesthetics (Novocain-like drugs)? Y N
- Penicillin, Amoxicillin, Cephalosporins? Y N
- Other antibiotics? Y N
- Barbiturates, sedatives? Y N
- Aspirin, ibuprofen, or other pain medicines? Y N
- Latex? Y N
- Codeine or other narcotics or opiods? Y N
- Other allergies or reactions? Y N
  Please List: _____
- Metal? Y N
- Sulfa Drugs? Y N
- Acrylic? Y N

Do you have any other medical conditions not listed above that you think the doctor should know about?

_____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment, to the best of my knowledge; the information above is complete and accurate.

Date____/____/_____ **Signature of responsible party**_____