solon family DENTAL

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First Name: _____ **Last Name**: _____ **Birthdate**: _____
Preferred Name (if different):_____ **SSN**: _____ **Marital Status**: _____
Gender: *Male* *Female* *Prefer not to answer*
Cell #: _____ **Texts ok?** *Y* *N* **Home #**: _____
Work #: _____ **Email address**: _____
Address: _____ **City**: _____ **State**: ____ **Zip**: _____
If this is your first visit, how did you hear about our office?: _____
(If someone referred you here, please tell us their name so we can thank them.)
Emergency Contact: _____ Phone: _____ Relation: _____
Physician Name:_____ Phone: _____
Preferred Pharmacy: _____ Phone: _____

Dental Insurance Information:

Do you have dental insurance? Y N

If yes, please fill out as much of the following information as possible.
If you have a copy of your card, you may provide that to the office staff in place of this section.

Insurance Company: _____ Patient's relationship to cardholder: *Self* *Spouse* *Dependent*
Cardholder's name: _____ DOB: _____ Employer: _____
Member ID # (or Cardholder's SSN): _____ Group #: _____
Group Name: _____ Insurance Phone #: _____

Dental Health Information: – Please check 'Y' or 'N':

Bleeding Gums	Y N	History of Mouth Injuries	Y N	Sensitive Teeth (Temperature/Sweets)	Y N
Dry Mouth	Y N	History of Periodontal Treatment	Y N	TMJ/Jaw Joint Pain	Y N
History of Braces	Y N	Mouth Sores or Ulcers	Y N	Is your home water non-fluoridated?	Y N
Dissatisfied with your smile?	Y N	Dental Anxiety?	Y N	Do you grind/clench your teeth?	Y N

Health Information:

Do you currently take any prescription OR over-the-counter medications? *Y* *N*
If yes, list them here:
_____
_____
_____

Do you take an antibiotic prior to all dental appointments per your physician? *Y* *N*
If yes, why do you premedicate?
_____

Are you pregnant? *Y* *N* *N/A*
(if yes, what is your due date?: _____)

Are you nursing? *Y* *N* *N/A*

CONTINUED ON BACK

Please check 'Y' or 'N' if you have or have ever had the following conditions:

Artificial Heart Valve	Y	N
Previous Infective Endocarditis	Y	N
Damaged Valves in Transplanted Heart	Y	N
Unrepaired, cyanotic congenital heart defect(s)	Y	N
Prosthetic material used for heart valve repair such as annuloplasty rings, chords or clips	Y	N
Repaired congenital heart defects w/ residual defects.	Y	N

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Abnormal Bleeding	Y	N
Acid Reflux/Persistent Heartburn	Y	N
Alcohol Abuse	Y	N
Anemia	Y	N
Angina Pectoris	Y	N
Arteriosclerosis	Y	N
Arthritis	Y	N
Autoimmune Disease	Y	N
Specify: _____		
Asthma	Y	N
Cancer (Type: _____)	Y	N
Cardiovascular Disease	Y	N
Chronic Bronchitis	Y	N
Chronic Pain	Y	N
Colitis/Ulcers	Y	N
Damaged Heart Valves	Y	N
Diabetes (Type:_____)	Y	N
Drug Abuse	Y	N
Eating Disorder	Y	N
Emphysema	Y	N
Epilepsy	Y	N
Fainting Spells	Y	N
Frequent Headaches/Migraines	Y	N
Glaucoma	Y	N
Heart Attack	Y	N
Hepatitis (Type:____)	Y	N
High Blood Pressure	Y	N
HIV/AIDS	Y	N
Jaundice or Liver Disease	Y	N
Joint Replacement (Date:_____)	Y	N
Kidney Problems	Y	N
Low Blood Pressure	Y	N
Mental Health Disorders	Y	N
Specify:_____		
Mitral Valve Prolapse	Y	N
Neurological Disorders	Y	N
Specify: _____		
Osteoporosis	Y	N
Other Congenital Heart Defects	Y	N
Pacemaker/Defibrillator	Y	N
Radiation Therapy	Y	N
Recurrent Infection	Y	N
Type:_____		
Rheumatic Fever	Y	N
Rheumatic Heart Disease	Y	N
Seasonal Allergies	Y	N
Seizures	Y	N
Shingles	Y	N
Sinus Problems	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Thyroid Problems	Y	N
Tobacco Use (Type:_____)	Y	N
Tuberculosis	Y	N

Allergies/Sensitivities:

Codeine	Y	N
Clindamycin	Y	N
Epinephrine	Y	N
Latex	Y	N
Metals	Y	N
NSAIDs	Y	N
Penicillin	Y	N
Tetracycline	Y	N
Minocycline	Y	N

Please list any other conditions and/or diseases not listed above: _____

_____

_____

Please list any other allergies not listed above: _____

_____

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____