

Cedar Valley Dental

Patient Information:

Mr. Mrs. Miss Ms. Dr. Last Name _____ First Name _____ Middle Initial _____ Preference _____
Home Address _____ Apt. # _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
(Please indicate which numbers are approved to receive calls)
Date of Birth _____ Sex: M F Social Security No. _____ Drivers License No. _____
Place of Employment _____ Position _____
City _____ State _____ Zip Code _____ E-mail Address _____

Insurance Information:

Plan _____ Group # _____ Ins. Phone # _____
Policy Holder's First and Last Name: _____ ID # _____ Social Security No. _____ DOB _____

If the patient is not responsible for payment of this account, please complete the following information:

Responsible Person:

Last Name _____ First Name _____ Middle Initial _____
Home Address _____ Apt. # _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
(Please indicate which numbers are approved to receive calls)
Social Security No. _____ Driver's License No. _____ Relationship to Patient _____ DOB _____
Place of Employment: _____ E-mail Address: _____

Emergencies:

Name and phone of closest relative to patient: Name _____ Relationship to Patient _____ Phone _____

How did you hear about our office? _____

MEDICAL HISTORY

Are you under a physician's care now? Why? _____ Phone # _____ YES NO
Have you ever been hospitalized or had a major operation? Discuss _____ YES NO
Have you ever had a serious injury to your head or neck? Discuss _____ YES NO
Are you taking any medications, pills, or drugs? What? _____ YES NO
Are you on a special diet? Discuss _____ YES NO
Are you allergic to any medications or substances? PLEASE INDICATE BELOW
 Aspirin Penicillin Codeine Novocaine Acrylic Metal Latex Rubber OTHER _____

WOMEN Please check: Pregnant / trying to get pregnant _____ Nursing? _____ Taking Birth Control? _____

Do you now have or have you ever had any of the following? Please check if appropriate.

<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A, B, or C
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Radiation	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Immune Deficiencies
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Epilepsy / Seizure	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis

Have you ever had any other serious illness not checked above? YES NO _____

Do you wish to talk to the dentist privately about any problem? YES NO _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment, without fail.

X _____ Date _____
Patient signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____