



PATIENT INFORMATION FORM

Today's Date: _____

Patient Name: _____
(First) (Last) (M.I.)

Preferred Name: _____ Gender: Male Female Other

Prefix: Dr. Miss Ms. Mrs. Mr. Not Specified

Degree: DDS DMD PA Jr. Sr. II

Date of Birth: _____ Marital Status: _____

SSN: _____ Driver's License: _____

Who should we thank for referring you? _____

CONTACT INFORMATION

Mailing Address: _____
(Street Address) (Apt/Unit #)

(City) (State) (ZIP Code)

Phone Numbers: Home: _____ Mobile: _____ Work: _____

Preferred contact method? Home Phone Mobile Other: _____

Email: _____

Patient Employer: _____ Occupation: _____ Work Phone: _____

EMERGENCY & MEDICAL CONTACTS

Emergency Contact: _____ Contact Number: _____

Relationship: _____

Family Doctor: _____ Contact Number: _____

MINOR / RESPONSIBLE PARTY

Is the patient a Minor? Yes No Full-time Student? Yes No

Name of Responsible Party: _____
(First) (Last) (M.I.)

Relationship to Patient: Both Parents Mother Father Other: _____



PATIENT MEDICAL HISTORY

What is the reason for your visit today?

Do you or have you had any of the following? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Congenital Heart Defects |
| <input type="checkbox"/> AIS or HIV Infection | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Swollen Glands in Neck |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Angina | <input type="checkbox"/> G.E. Reflux | <input type="checkbox"/> Recurrent Infections |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Severe Headaches/Migraines |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Severe or Rapid Wgt Loss |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> STDs or STIs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Rhythm Disorder | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Low Pain Tolerance | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Neurological Disorders | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Night Sweats | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Osteoporosis/Paget's | |



MEDICAL QUESTIONS

- Are you under medical treatment now? Y N
- Have you ever been hospitalized for any surgical operation or illness? Y N
- Do you require Pre-medication? Y N
- Are you taking any medications(s) including non-prescription medicine? Y N
- If yes, what medication(s) are you taking?* _____
- Are you pregnant or think you may be pregnant? Y N
- Are you nursing? Y N
- Are you taking birth control pills? Y N
- Do you use tobacco? Y N
- Do you use illicit drugs? Y N
- Are you wearing contact lenses? Y N

ALLERGIES

Are you allergic to or have you had any reactions to the following?

- Latex Local Anesthetics Antibiotics Sulfa Drugs Barbiturates
- Sedatives Iodine Aspirin Other: _____

DENTAL HISTORY

- Do your gums bleed when you brush or floss? Y N
- Are you currently experiencing dental pain or discomfort? Y N
- Are your teeth sensitive to cold, hot, sweets, or pressure? Y N
- Does food or floss catch between your teeth? Y N
- Have you had any periodontal (gum) treatment? Y N
- Have you ever had orthodontic (braces) treatment? Y N
- Have you had any problems associated with previous dental treatment? Y N
- Is your home water supply fluoridated? Y N
- Do you drink bottled or filtered water? Y N
- Do you have earaches or neck pains? Y N
- Do you have any clicking, popping, or discomfort in your jaw? Y N
- Do you grind your teeth? Y N
- Do you have any sores or ulcers in your mouth? Y N
- Do you wear partial dentures? Y N
- Do you wear full dentures? Y N
- Have you ever had a serious injury to your head, neck or mouth? Y N



SLATE DENTAL
YOUR SMILE IS PRICELESS

CERTIFICATION & CONSENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Slate Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to practitioners. I understand that I am responsible for payment of all services rendered; and all late accounts may be subject to a service charge.

Signature: _____

Date: _____