Sugarhill Dental

Christopher Kindig, D.M.D.

PATIENT INFORMATION FORM

PATIENT NAME _____NICKNAME_____ DATE_____

LOCAL ADDRESS_____ CITY _____ZIP_____

ALT. ADDRESS_____ CITY/STATE_____ZIP_____

HOME PHONE ( ) _____ CELL PHONE ( ) _____

DATE OF BIRTH _____/_____/_____ AGE _____ SEX _____MARITAL STATUS _____

SOCIAL SECURITY # _____ SPOUSE'S NAME_____

REFERRED BY _____

EMAIL _____

EMPLOYER NAME _____WORK PHONE ( )_____

EMPLOYER ADDRESS _____

PARENT / LEGAL GUARDIAN (IF PATIENT IS A MINOR)_____

IN CASE OF EMERGENCY (CLOSEST RELATIVE OR FRIEND)

NAME _____RELATIONSHIP_____PHONE NUMBER _____

FAMILY PHYSICIAN _____OFFICE PHONE _____

DENTAL INSURANCE PLAN NAME_____ ID#_____ PHONE #_____

POLICY HOLDER'S NAME_____ D.O.B_____

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MEDICAL HISTORY FORM

PATIENT NAME _____

DO YOU HAVE ANY INFLAMED AREAS, GROWTHS OR SORE SPOTS IN OR AROUND YOUR MOUTH? **YES NO**

IF YES, DESCRIBE _____

ARE THERE ANY CHANGES IN YOUR HEALTH IN THE PAST YEAR? **YES NO**

EXPLAIN:_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? **YES NO**

NAME OF PHYSICIAN _____PHONE NUMBER _____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? **YES NO**

IF YES, EXPLAIN _____

HAVE YOU HAD ABNORMAL BLEEDING WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA? **YES NO**

HAVE YOU EVER TESTED POSITIVE FOR HIV INFECTION OR AIDS? **YES NO**

HAVE YOU EVER HAD SURGERY AND/OR RADIATION FOR A TUMOR, GROWTH OR OTHER CONDITION? **YES NO**

IF SO, PLEASE STATE THE DATE OF DIAGNOSIS AND TREATING PHYSICIAN_____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ONE)

HIGH BLOOD PRESSURE	YES NO		STOMACH ULCERS, COLITIS	YES NO
HEART MURMUR OR MVP (CIRCLE)	YES NO		HEPATITIS, JAUNDICE, LIVER DISEASE	YES NO
DIABETES	YES NO		KIDNEY PROBLEMS	YES NO
JOINT PROSTHESIS (HIP, KNEE, ETC.)	YES NO		PSYCHIATRIC PROBLEMS	YES NO
RHEUMATIC HEART DISEASE OR FEVER	YES NO		FAINTING PROBLEMS	YES NO
CONGENITAL HEART DISEASE	YES NO		EPILEPSY	YES NO
CARDIOVASCULAR DISEASE, HEART ATTACK, STROKE OR BYPASS	YES NO		CANCER IF YES, WHAT TYPE	YES NO
PROSTHETIC HEART VALVE	YES NO		LOW BLOOD PRESSURE	YES NO
BLOOD DISORDER (E.G. ANEMIA)	YES NO		DO YOU SMOKE/AMOUNT_____	YES NO
VENEREAL DISEASE	YES NO		TEMPOROMANDIBULAR JOINT PROBLEMS (TMJ)	YES NO
ASTHMA	YES NO		LOW BLOOD SUGAR	YES NO
CHEST PAIN, ANGINA	YES NO		DIALYSIS	YES NO
SWOLLEN ANKLES, ARTHRITIS OR JOINT DISEASE (CIRCLE)	YES NO		IRREGULAR HEART BEAT	YES NO
CARDIAC PACEMAKER	YES NO		CONTAGIOUS DISEASES	YES NO
HEART SURGERY	YES NO		BRONCHITIS, CHRONIC COUGH	YES NO
DELAY IN HEALING	YES NO		HAY FEVER OR SINUS PROBLEMS	YES NO
TUBERCULOSIS	YES NO		PROBLEMS WITH THE IMMUNE SYSTEM	YES NO
EMPHYSEMA	YES NO		DIFFICULT BREATHING/LUNG TROUBLE	YES NO
RADIATION OR CHEMOTHERAPY	YES NO		CHRONIC FATIGUE OR NIGHT SWEATS	YES NO
ON A DIET	YES NO		HISTORY OF DRUG ABUSE	YES NO
HISTORY OF ALCOHOL ABUSE	YES NO		WEAR CONTACT LENSES	YES NO
EYE DISEASE OR GLAUCOMA	YES NO		BRUISE EASILY	YES NO

DO YOU REQUIRE AN **ANTIBIOTIC** PRE-MEDICATION PRIOR TO ALL **ROUTINE** DENTAL WORK? **YES NO**

REASON FOR PRE MEDICATION_____ ANTIBIOTIC USED? _____

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN BISPHOSPHONATE MEDICATION, SUCH AS ACTONEL, RECLAST OR FOSAMAX WITHIN THE PAST TWELVE YEARS? **YES NO**

ARE YOU ALLERGIC TO OR HAVE HAD ANY PROBLEMS WITH: (PLEASE CIRCLE ONE)

PENICILLIN	**YES NO**	IF YES, PLEASE EXPLAIN _____
OTHER ANTIBIOTICS	**YES NO**	IF YES, PLEASE LIST _____
CODEINE	**YES NO**	IF YES, PLEASE EXPLAIN_____
ASPIRIN	**YES NO**	IF YES, PLEASE EXPLAIN_____
NSAIDS (I.E. ADVIL, ALEVE)	**YES NO**	IF YES, PLEASE EXPLAIN_____
DENTAL ANESTHESIA	**YES NO**	IF YES, PLEASE EXPLAIN_____
LATEX	**YES NO**	IF YES, PLEASE EXPLAIN_____

OTHER _____

DO YOU TAKE ANY MEDICATION, INCLUDING NON-PRESCRIPTION? **YES NO**

IF YES, PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

_____

_____

DO YOU TAKE VITAMIN/HERBAL SUPPLEMENTS? **YES NO**

IF YES, PLEASE LIST AND GIVE REASON FOR TAKING (OR ATTACH LIST)

_____

IS THERE ANYTHING ELSE IN YOUR MEDICAL HISTORY OF SIGNIFICANCE? _____

_____

FOR FEMALE PATIENTS ONLY

IS THERE A POSSIBILITY THAT YOU ARE PREGNANT?	**YES NO**	DUE DATE _____
ARE YOU CURRENTLY NURSING	**YES NO**	
ARE YOU CURRENTLY TAKING BIRTH CONTROL	**YES NO**	

PLEASE NOTE: ANTIBIOTICS (SUCH AS PENICILLIN) MAY ALTER THE EFFECTIVENESS OF MANY FORMS OF BIRTH CONTROL. CONSULT YOUR PHYSICIAN / GYNECOLOGIST FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL.

PATIENT SIGNATURE _____DATE _____
(OR PARENT'S OR LEGAL GUARDIAN SIGNATURE)

PLEASE PRINT PATIENT NAME _____