Patient Information

PARK PLACE DENTAL

Date:_____

Name:_____ I prefer to be called_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Email Address:_____ Date of Birth:_____

Social Security Number: _____

Responsible Party - If Under the Age of 18

Relationship to Patient: SELF SPOUSE PARENT OTHER_____

Name:_____Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Work Number: (_____)_____

Social Security Number: _____ Date of Birth:_____

HEALTH HISTORY

Please list all the names and phone numbers of the physicians who are currently providing you care:

1._____

2._____

3._____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Are you Pregnant?	No	Yes	Heart Disease, Heart Attack, Heart Surgery	No	Yes
Allergies	No	Yes	Heart Stent? When Placed?	No	Yes
Anemia or Blood Disorder	No	Yes	Hepatitis, Any Form	No	Yes
Abnormal Bleeding from a cut?	No	Yes	High Blood Pressure	No	Yes
Cancer of Tumor?	No	Yes	Joint Replacement? When placed?	No	Yes
Diabetes	No	Yes	Kidney Disease	No	Yes
Emphysema or other Respiratory/Lung Illness	No	Yes	Liver Disease (including Jaundice)	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Slow Healing Mouth Sores	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Congenital Heart Disease	No	Yes			

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?	No	Yes

Please list any medications you are currently taking and dosages:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Please list any allergies:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

* _____ * _____ * _____

Patient (Print Name) *Patient Signature* *Date*

* _____ * _____ * _____

Doctor (Print Name) *Doctor Signature* *Date*