MID WILSHIRE DENTISTRY

PATIENT INFORMATION SHEET

Please Print Clearly (***This information is necessary for our files and will be considered CONFIDENTIAL)*** DATE: ________________

Patient's Name____ Age ____________ Birthday______________
Last Name First Name

Residence Address ____
Street City Zip

Social Security Number: ______________________________ E-Mail: ______________________________

Whom may we thank for referring you? ______________________________ Home #: ______________________

Occupation: ______________________________ Employer: ______________________________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Live-in ☐ Widowed ☐ Divorced Cell#: ______________________

Male ☐ Female ☐ Employed ☐ FT Student ☐ PT Student ☐ Retired ☐ Unemployed ☐ Work#: ______________________

Ethnicity (select one): ☐ African American ☐ Caucasian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic ☐ Japanese ☐ Korean ☐ Native American ☐Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Vietnamese ☐ Other Asian ☐ Other Pacific Islander ☐ Other

RESPONSIBLE PARTY INFORMATION

Last Name		First Name		MI
Date of Birth:	Home #:	Cell#:	Work#:	E-Mail:
Home Address		City	State	Zip Code

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company	Policy #:		Employer	
Subscriber's Name:	Group #:		Coverage Code	Effective Date:
Date of Birth:	Sex: Male ☐ Female ☐		Home #:	Work#;
Address:		City:	State:	Zip Code:
Check one (Patient's relationship to Insured):	☐ Self ☐Spouse ☐Child ☐Parent ☐Other (Please Specify):			

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company	Policy #:		Employer	
Subscriber's Name:	Group #:		Coverage Code	Effective Date:
Date of Birth:	Sex: Male ☐ Female ☐		Home #:	Work#;
Address:		City:	State:	Zip Code:
Check one (Patient's relationship to Insured):	☐ Self ☐Spouse ☐Child ☐Parent ☐Other (Please Specify):			

MEDICAL INSURANCE INFORMATION

Insurance Company	Policy #:		Employer	
Subscriber's Name:	Group #:		Coverage Code	Effective Date:
Date of Birth:	Sex: Male ☐ Female ☐		Home #:	Work#;
Address: ☐		City:	State:	Zip Code:
Check one (Patient's relationship to Insured):	☐ Self ☐Spouse ☐Child ☐Parent ☐Other (Please Specify):			

EMERGENCY CONTACT

Name (Parent, Spouse, Legal Guardian)	Relationship:	Home/Cell #:

MEDICAL INFORMATION: ***Please mark (X) your response to indicate if you have or have not any of the following disease of problems***

WOMEN ONLY Are you:

Pregnant? .... Yes No DK
Number of weeks .... Yes No DK
Taking birth control pills or hormonal replacement? .... Yes No DK
Nursing? .... Yes No DK

Severe Headaches / migraines Yes No DK
Do you snore? Yes No DK
Sleep Disorder Yes No DK

Allergies. Are you allergies to or have you has a reaction to: To all ***YES*** responses specify type of reaction.

Local anesthetics ______________ Yes No DK
Aspirin ______________ Yes No DK
Penicillin or other antibiotics ______________ Yes No DK
Sulfa Drugs ______________ Yes No DK
Barbiturates, sedatives, or sleeping pills Yes No DK
Codeine or other narcotics ______________ Yes No DK
Latex (rubber) ______________ Yes No DK
Metals ______________ Yes No DK
Iodine ______________ Yes No DK
Hay fever / seasonal Yes No DK

Do you wear contact lenses? **Yes No DK**

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, and finger) replacement? **Yes No DK**
Date: ______________ if yes, have you had any complications? ______________
Are you taking or scheduled to begin taking
An antiresorptive agent (like Fosamax, Actonel,Boniva, Reclast, Prolia) for Osteoporosis or Paget's Disease? **Yes No DK**
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer? **Yes No DK**
Date Treatment began:

Artificial (prosthetics) heart valve .... Yes No DK
Previous infective endocarditis .... Yes No DK
Damaged valves in transplanted heart .... Yes No DK
Congenital heart disease (CHD)
Unrepaired, cyanotic CHD .... Yes No DK
Repaired (completely in last 6 months .... Yes No DK
Repaired CHD with residual defects .... Yes No DK
Cardiovascular disease .... Yes No DK
Angina .... Yes No DK
Arteriosclerosis .... Yes No DK
Congestive heart failure .... Yes No DK
Damaged heart valves .... Yes No DK
Heart attack .... Yes No DK
Heart murmur .... Yes No DK
Low blood pressure .... Yes No DK
High blood pressure .... Yes No DK
Other congenital heart defects .... Yes No DK
Mitral valve prolapsed .... Yes No DK
Pacemaker .... Yes No DK
Rheumatic fever .... Yes No DK
Rheumatic heart disease .... Yes No DK

Anemia .... Yes No DK
Blood transfusion .... Yes No DK
If yes, Date: ______________
Hemophilia .... Yes No DK
AIDS or HIV infection .... Yes No DK
Athritis .... Yes No DK
Suystematic lupus
erythematosus .... Yes No DK
Asthma .... Yes No DK
Emphyema .... Yes No DK
Sinus trouble .... Yes No DK
Tuberculosis .... Yes No DK
Cancer/ Chemotherapy /
Radiation treatment .... Yes No DK
Chest pain .... Yes No DK
Diabetes Type I or II .... Yes No DK
Eating disorder .... Yes No DK
Malnutrition .... Yes No DK
Gastrointestinal disease .... Yes No DK
G.E Reflux / persistent
heartburn .... Yes No DK

Ulcer .... Yes No DK
Thyroid problems .... Yes No DK
Stroke .... Yes No DK
Glaucoma .... Yes No DK
Hepatitis, jaundice or liver disease .... Yes No DK
Epilepsy .... Yes No DK
Fainting spells or seizures .... Yes No DK
Neurological disorders .... Yes No DK
Neurological disorders .... Yes No DK
Specify ______________
Mental health disorders .... Yes No DK
Specify ______________
Recurrent Infections .... Yes No DK
Type of infection ______________
Kidney problems .... Yes No DK
Night sweats .... Yes No DK
Osteoporosis .... Yes No DK
Persistent swollen glands in neck .... Yes No DK
Severe or rapid weight loss .... Yes No DK
Sexually transmitted disease .... Yes No DK

HEALTH QUESTIONNAIRE MUST BE UPDATED EVERY YEAR

Date ______________ Signature ______________

Year 2
Date ______________ Signature ______________

Year 3
Date ______________ Signature ______________

REVIEWED BY:

YEAR 1 *sig* ______________ *date* ______________

YEAR 2 *sig* ______________ *date* ______________

YEAR 3 *sig* ______________ *date* ______________

CONSENT FOR TREATMENT: I hereby grant authority to the dentist (s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and / or drugs. **All services are rendered and accepted under the terms and conditions printed on the reverse hereof**

Signed: ______________ Date: ______________
Authorization must be signed by the patient, or by the nearest relative in the cause of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: ______________