The Khisti Dental Center

PATIENT INFORMATION

Patient Name_____ SS#_____

Last First MI

Birth date_____ Age_____ Sex: M F

Circle appropriate: Single Married Widowed Separated Divorced

Address_____

Street City State Zip

Home Phone #_____ Work Phone #_____ Cell Phone #_____ E-Mail_____

Occupation_____ Employer_____ Phone #_____

Spouse's Name_____ Do you have children? Yes No How Many?_____

If minor, parent or guardian name_____ Parent/Guardian Employer_____

How did you hear about us? _____

Emergency Contact: Name_____ Relationship_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

DENTAL INSURANCE INFORMATION

Insurance Company_____ Group #_____ Telephone #_____

Subscriber's Name_____ Subscriber's Employer_____

Birth date_____ SS/ID #_____ Relationship to Patient_____

Is patient covered by additional insurance? Yes No If yes, please provide necessary information to staff member.

MEDICAL INFORMATION

Physician Name_____ Phone #_____

Are you under the care of a physician (other than for routine physicals)? Yes No

Are you in good health? Yes No Date of last physical exam_____

Have there been any changes in your general health within the past year? Yes No

If yes, what condition is being treated?_____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem?_____

Are you taking or have recently taken any prescription or over the counter medicine(s)? Yes No

If yes, please list all (including vitamins, natural or herbal preparations and/or diet supplements) on the ***attached form.***

PATIENT MEDICAL HISTORY

Check if you have or have had any of the following:

___ Anesthesia Allergy

___ Allergies, Other

_____

___ Anemia/Hemophilia

___ Arthritis/Rheumatism

___ Artificial Heart or Valves

___ Asthma

___ Autoimmune Disease

___ Bacterial Endocarditis

___ Blood Disease/Disorder

___ Blood Transfusion

___ Cancer/Leukemia

___ Chemical Dependency (alcohol or drug)

___ Chemotherapy

___ Chronic Pain

___ Circulatory Problems

___ Codeine Allergy

___ Congenital Heart Defects

___ Congestive Heart Failure

___ Cough, Persistent or Bloody

___ Diabetes

___ Eating Disorder

___ Emphysema/COPD

___ Epilepsy

___ Excessive Urination

___ Fainting/Seizures

___ Gastrointestinal Disease

___ GE Reflux/Persistent Heartburn

___ Glaucoma

___ Headaches or Migraines (frequent or severe)

___ Heart Attack

___ Heart Disease

___ Heart Murmur

___ Heart Surgery/Stents

___ Hepatitis Type___

___ High Blood Pressure

___ HIV/AIDS

___ Hypoglycemia

___ Jaundice

___ Latex Allergy

___ Liver Disease

___ Low Blood Pressure

___ Metal Allergy

___ Osteoporosis/Osteopenia

___ Pacemaker

___ Peanut Allergy

___ Penicillin Allergy

___ Persistent Swollen Neck Glands

___ Psychiatric Care/Problems

___ Radiation

___ Severe or Rapid Weight Loss

___ Sexually Transmitted Disease

___ Sinus Trouble

___ Skin Rash/Hives

___ Stomach Problems

___ Stroke

___ Swollen Feet or Ankles

___ Systemic Lupus

___ Taking Blood Thinners

___ Tetracycline Allergy

___ Thyroid Problems

___ Tuberculosis

___ Tumor or Growth on Head or Neck

___ Ulcer

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

Please explain: _____

Are you taking or scheduled to begin any bisphosphonate or similar medication for osteopenia, osteoporosis, bone disease, or metastatic cancer (I.V. or oral)? Yes No

Do you use tobacco (smoking or smokeless)? Yes No

Any Joint Replacement-Have you had hip, knee, shoulder, elbow, or finger replacement? Yes No Date: _____

WOMEN ONLY

Are you pregnant? Yes No Number of weeks_____ Nursing? Yes No Taking birth control pills? Yes No