# Portland Dental
# PATIENT INFORMATION

Patient's Name _____ Preferred Name _____ Birth Date_____Age_____

***Responsible Party***:

If minor, Guardian/Parent's Name _____ Birth Date_____ Relation To Patient_____

Mailing address _____ City _____State _____ Zip _____

Work/Home phone _____ Cell phone _____ Driver's License #:_____ State:_____

Employer _____ Occupation _____Social Securtity Number_____

Email Address_____Whom may we thank for referring you to our office? _____

Last Dental Visit?_____ Reason for today's Visit?_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Name of Primary_____Primary's Social Security number _____ Primary's Birthdate _____

Primary's Employer_____ Dental Insurance Company _____

Plan number _____ Group number_____ Insurance's Phone Number _____

Insurance's Address:_____

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____ Phone Number:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

Signature of patient (or parent) _____ Date _____