WEBER
Family Dentistry

PATIENT INFORMATION SHEET

Patient Name _____ Birthdate _____/_____/_____
Last First MI

Address _____ City_____ State_____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Social Security Number _____-_____-_____ Driver's License Number _____-_____-_____

Your Employer _____ Occupation _____

Address _____ How Long Employed _____

Spouse's Name (If minor, parent or guardian's name) _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Name of Nearest Relative (not living with you) _____

Address _____ Phone _____

Relationship _____

Whom May We Thank For Referring You To Our Office? _____

DENTAL INSURANCE INFORMATION

Insurance Company _____

Insured's Name _____ Employer _____

Insured's Social Security Number _____-_____-_____ Birthdate _____

Group Number _____ Local Number _____

Secondary Insurance Company _____

Insured's Name _____ Employer _____

Insured's Social Security Number _____-_____-_____ Birthdate _____

Group Number _____ Local Number _____

Signature _____ Date _____

Parent or Guardian, if minor _____

Please indicate if you have experienced any of the following:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Coumadin
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Gag Reflex
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Use the space below to elaborate on any of the above responses or any issues not covered above:

_____

_____

List below any medications you are taking:

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

_____

RELATIONSHIP TO PATIENT

RESPONSE DATE _____

WEBER Family Dentistry

MEDICAL AND DENTAL HISTORY FORM

Patient Name _____ _____ ____ _____
Last *First* *MI* *Preferred Name*

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that protects your overall health and well-being.

Would you consider yourself to be in fairly good health?

☐ Yes ☐ No

Within the past year, have there been any changes in your general health?

☐ Yes ☐ No

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, and phone number:

_____

Please mark any of the following to indicate 'Yes' in response to the question:

☐ Have you ever taken Fosamax, Actonel, Boniva, or any other medications containing Bisphosphonates?
☐ Have you ever taken Coumadin, Plavix, Heparin, or any other anti-platelet or blood-thinning medications?
☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to surgery or illness?
☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: **Are you pregnant?** ☐ Yes ☐ No If yes, when is the due date? _____

PLEASE COMPLETE THE BACK OF THIS FORM