THOMPSON
Family Dentistry

Patient Information

DATE:_____

Date of Birth:_____

Patient Name:_____

(First) (Middle) (Last)

Address:_____

(Street) (City) (State) (Zip code)

Phone Number: Cell- _____ Home- _____Work-_____

Employer:_____ **Phone Number:**_____

Social Security #: _____ **Driver's License/ID #:** _____

Marital Status:_____ **Email:**_____

Emergency Contact

Name:_____ Relationship: _____Phone Number:_____
Name:_____ Relationship: _____Phone Number:_____
Name:_____ Relationship: _____Phone Number:_____

Dental Insurance Information

Primary Insurance

Insured's Name:_____Insurance Co Name:_____
Subscriber ID:_____ Group#:_____
Insured's DOB:_____Insured's SS#:_____
Insured's Employer:_____Relationship to Patient:_____

Secondary Insurance

Insured's Name:_____Insurance Co Name:_____
Subscriber ID:_____ Group#:_____
Insured's DOB:_____Insured's SS#:_____
Insured's Employer:_____Relationship to Patient:_____

Responsible Party (If a Minor)

Name: _____Phone:_____ Signature: _____

Signature:_____

Health History Update

Please list all major surgeries you've had in the past 5 years below:

_____

_____

Do you have or have you had any of the following conditions

- ☐ Are you receiving any injections, transfusions, or medication for bone density or osteoporosis? If so explain _____
- ☐ Do you require antibiotics before dental treatment?
- ☐ Are you currently taking any blood thinners?
- ☐ Acid Reflux
- ☐ AIDS
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Artificial Joints- Hip/Knee/other, if so when?
- ☐ Asthma/Breathing Problems
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Valve Defect
- ☐ Cortisone Treatments
- ☐ Currently Pregnant
- ☐ Diabetes/ Insulin
- ☐ Dry Mouth
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Food Allergies
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Murmur/ Mitral Valve Prolapse
- ☐ Heart Valve Replacement
- ☐ Hepatitis Type
- ☐ Herpes Type
- ☐ High Blood Pressure/ Low Blood Pressure
- ☐ History of Drug Addiction
- ☐ History of Emotional or Nervous Disorder
- ☐ Immune Suppress Disorder
- ☐ Infective Endocarditis
- ☐ Kidney Disease
- ☐ Liver Disease/Jaundice
- ☐ Mono
- ☐ Pacemaker
- ☐ Prolonged Bleeding Disorder
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Smoke or use of tobacco
- ☐ STD/Venereal disease
- ☐ Thyroid Conditions
- ☐ Tuberculosis or lung disease
- ☐ Ulcers
- ☐ ANY CONDITIONS NOT LISTED?

_____

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal or plastics
- ☐ Nitrous Oxide
- ☐ Penicillin/Antibiotics (be specific)
- ☐ Sulfa Drugs
- ☐ Other (please specify)

_____

_____

_____

Please list ALL medications you're currently taking below:

_____

_____

_____

Signature:_____Date:_____