Pleasant Valley Dentistry

Patient Name:_____ Date:_____

Preferred Name:_____ Birthdate:_____ SSN:_____

Email:_____

Male___ Female___ Cell Phone:_____ OK to Text? Y / N

Address:_____ City:_____ Zip Code:_____

Occupation:_____ Employer:_____

Single__ Married__ Divorced___ Widowed__ Name of Spouse:_____

If minor, name of parent/guardian:_____

Whom may we thank for this referral?_____

Emergency Contact Information

Name:_____ Relationship:_____

Address:_____

Phone:_____

Is another member of your family a patient at our practice? Y / N - Name:_____

When was your last dental cleaning?_____ Last taken x-rays?_____

Dental Insurance Information

Insurance Company:_____

Insurance Company Address/P.O. Box:_____

Name of Policy Holder:_____ Birthdate:_____

Member ID:_____ Group Number:_____

SSN:_____ Employer:_____

If you would like us to file dental claims on your behalf, please provide us with the above information. Otherwise, payment is the patient's responsibility on the day of service. Thank you

Initial Here:_____

Medical History

Have you been under the care of a medical doctor in the past 2 years? Y / N
If so, explain:_____

Have you ever been hospitalized? Y / N
If so, explain:_____

***Please circle if you are allergic to the following**: **Penicillin Aspirin Codeine Latex Sulfa Other**
If other, please list:_____

Have you ever taken Fosamax or any other bisphosphate? Y / N

Are you currently having any dental problems at this time? Y / N
If so, please explain:_____

Do you experience nervousness/anxiety about having dental work done? Y / N

***Do you require/take an antibiotic pre-medication prior to having dental work done**? Y / N
If so, please explain:_____

Do you smoke and/or use tobacco in any form? Y/N
If so, what form?_____

Women: **Are you pregnant, or trying to become pregnant?** Y / N If so, how far along?_____

Please list ALL medications you are currently taking:_____

_____

Circle any of the following conditions you have had or currently have:

-Anemia
-Arthritis
-Artificial Heart Valve
-Artificial Joint _____
-Asthma
-Auto-Immune Disease
-Cancer
-Cold Sores/Fever Blisters
-Diabetes
-Emphysema
-Epilepsy/Seizures
-Heart Disease or Attack
-Heart Murmur/Mitral Valve
-Heart Pacemaker
-Heart Surgery
-Hemophilia/Abnormal Bleeding
-High Blood Pressure
-High Cholesterol
-HIV Positive
-Hay Fever
-Kidney Disease/Failure
-Liver Disease
-Osteoporosis
-Psychiatric Problems
-Rheumatic Fever
-Shortness of Breath
-Stroke
-Thyroid Disease
-Ulcers
-Other

If other, please list:_____

We are pleased to meet you, and look forward to meeting your friends and family!

Patient/ Parent or Guardian Signature:_____ **Date:**_____

For office use only : (Date and Initial) _____