IRIS DENTAL GROUP

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Welcome to our office. To assist us in serving you, please complete the following confidential form.

The information provided is important to your dental health

Patient's Name :

Prefferred Name :

Birth date :

If Minor, Parent/ Guardian's Name :

Home Phone :

Cell Phone :

Mailing Address :

City:

Postal Code :

E-Mail :

Occupation :

Employer :

Whom we may thank for referring you to our office :

BILLING, CREDIT AND INSURANCE INFORMATION

Covered by Dental Insurance : Yes No

If yes, Insurance company :

Policy No :

ID :

Covered by spouse's Dental Insurance : Yes No

If yes, Spouse's name :

Insurance company :

Policy No :

ID :

Spouse's birth date :

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 prolapsed or heart defect
- Rheumatic fever or Rheumatic Heart disease
- Artificial joint or valve
- Pacemaker
- High or low blood pressure
- Tuberculosis or other lung diseases
- Kidney disease
- Hepatitis or other liver diseases
- Alcoholism
- Blood transfusion
- Diabetes
- Neurological conditions
- Epilepsy, Seizures, or fainting spells
- Emotional conditions
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine head ache or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extraction, surgery or trauma
- Hay fever or sinus trouble
- Allergies or Hives
- Asthma

Do you smoke or chew Tobacco : Yes No

Do you have or have you had 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

Any 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 diabetic drugs
- Nitroglycerine
- Cortisone or other steroids
- Osteoporosis (bone density medicines)
- Thyroid medicines

Any Other _____

Are you taking any of the following?

- May be pregnant
  - Expected date of delivery
- Taking hormones or contraceptives

Do you have any other disease or condition or problem not listed above :

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

Name of your Physician :

Signature of the patient/parent/Guardian :

Date :