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_____ Preferred 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 ☐

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
- ☐ 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_____

Women:

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

Name of your Physician_____

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

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

Signature of the patient (or parent or Guardian)_____Date_____