

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 _____