IRVING DENTAL CARE

Name:_____
last first

Spouse:_____

Parent (if child):_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: Home_____ Work_____

Cell_____

Where do you work:_____

Child lives with: both parents_____ mother_____ father_____

Patient date of birth:_____

Social Security #:_____

Date of last medical physical:_____

Physician name & phone#:_____

In case of emergency, notify:_____

How did you hear about us:_____

Your E-Mail:_____

HEALTH INFORMATION

Are you in good health?	Yes	No
DO YOU HAVE A HISTORY OF:		
1. Rheumatic fever	☐	☐
2. Heart Murmur	☐	☐
3. Heart Trouble	☐	☐
4. Heart Valve Disorder	☐	☐
5. Mitral Valve Prolapse	☐	☐
6. Heart Surgery (Bypass)	☐	☐
7. Pacemaker	☐	☐
8. ____High or _____ Low Blood Pressure	☐	☐
9. Blood Disease	☐	☐
10. Liver Disease	☐	☐
11. Kidney Disease	☐	☐
12. Lung Disease	☐	☐
13. Asthma	☐	☐
14. Tuberculosis	☐	☐
15. Sinus Problem	☐	☐
16. Diabetes	☐	☐
17. Artificial Joints	☐	☐
18. Artifical Heart Valves	☐	☐
19. Metal Implants, Screws or Plates	☐	☐
20. HIV+ or AIDS	☐	☐
21. Hepatitis	☐	☐
22. Epilepsy	☐	☐
23. Cancer (Radiation Treatment)	☐	☐
24. Venereal Disease	☐	☐
25. Arthritis	☐	☐
26. Organ Transplant	☐	☐
27. Fainting or Dizziness	☐	☐
28. Are you Pregnant	☐	☐
29. Are you Nursing	☐	☐
30. Are you taking Aspirin	☐	☐
31. Are you taking Blood Thinners	☐	☐
32. Thyroid Disease (Goiter)	☐	☐
33. Are you taking or have you ever taken	☐	☐
Bisphosphonates for Osteoporosis, (Fosamax)	☐	☐
Actonel, Boniva).	☐	☐

List any Medications you are taking:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Are you Allergic to any Medication:

1._____

2._____

3._____

Date of Last Dental Visit_____

Reason for Dental Visit_____

Date of Last Routine Cleaning & Exam_____

Date of Last dental Xrays_____

If Wearing Full or Partial Dentures, Age of Dentures_____

Latex or Rubber Products Allergies_____

Do you have any disease, condition or problem not listed above_____

DENTAL INSURANCE INFORMATION

Primary Carrier_____

Subscriber_____

ID#_____ Grp#_____

P_____ B_____ M_____

Ded_____ Max_____

Insurance Limit_____

Secondary Carrier_____

Subscriber_____

ID#_____ Grp#_____

P_____ B_____ M_____

Ded_____ Max_____

Insurance Limit_____

Signature Patient or Parent_____

Date_____

Reviewed By_____