CALEDONIA
FAMILY DENTISTRY

Patient Information

First Name: _____ Middle: _____ Last Name: _____

Preferred Name: _____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Street Address: _____ City: _____ State: _____ Zip code: _____

Preferred Phone Number: _____ Is this a mobile/cell number? ☐ Yes ☐ No

Secondary Phone Number: _____ Email Address: _____

Emergency Contact:_____ Emergency Phone Number:_____

Responsible Party

First Name: _____ Middle: _____ Last Name: _____

Street Address _____ City: _____ State: _____ Zip code:_____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Primary Dental Insurance

Is the subscriber the same as the patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Employer Name/Company: _____

Insurance Company: _____ Insurance Phone Number: _____

Subscriber ID/Policy Number: _____ Group Number: _____

Subscriber SSN: _____

Patient Relationship to Subscriber: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other Dependent

Secondary Dental Insurance

Is the subscriber the same as the patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Employer Name/Company: _____

Insurance Company: _____ Insurance Phone Number: _____

Subscriber ID/Policy Number: _____ Group Number: _____

Subscriber SSN: _____

Patient Relationship to Subscriber: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other Dependent

PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:**_____ **Today's Date:** _____

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name:_____ Physician's Phone Number: _____

Do you require premedication/antibiotic prior to dental treatment? ☐ Yes ☐ No If yes, for what and what type?_____

Are you allergic to or have you had any adverse reactions to any of the following?
☐ Amoxicillin/Penicillin ☐ Epinephrine ☐ Latex ☐ Lidocaine ☐ Sulfa ☐ Metals ☐ None
☐ Other Allergies:_____

Have you ever been hospitalized? ☐ Yes ☐ No If yes: _____

Are you taking/have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No If yes:_____

Are you taking/have you taken Oral Bisphosphonates (ex. FOSAMAX, BONIVA) or IV Bisphosphonates (ex. ZOMETA, AREDIA)?
☐ Yes ☐ No If yes, When and For How Long? _____

Are you taking any Blood Thinners (ex. Coumadin, Warfarin, Plavix etc.)? ☐ Yes ☐ No If yes, please describe: _____

Women: Are you Pregnant? ☐ Yes ☐ No If yes, estimated delivery date: _____
Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

List any medications you are currently taking, including non-prescription drugs and herbals/vitamins: ☐ None

_____
_____
_____
_____

Check any conditions that apply to you:

☐ Artificial Joints - Type:_____
☐ Artificial Heart Valve
☐ Diabetes - Type:_____
☐ Allergies
☐ Anemia
☐ Asthma
☐ Alzheimer's/Dementia
☐ Aspirin Therapy
☐ Cancer - Type:_____
☐ ChemoTherapy
☐ Dialysis
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Tuberculosis
☐ Blood Thinners/Coumadin
☐ Blood Transfusion
☐ Breathing Problems
☐ Fainting/Dizziness
☐ Hearing Impairment
☐ Heart Murmur
☐ Heart Surgery Date:_____
☐ Heart Trouble Type:_____
☐ Hepatitis
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Lupus
☐ Visual Impairment
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Lung Disease/COPD
☐ Mitral Valve Prolapse
☐ Organ Transplant - Type:_____
☐ Pace Maker
☐ Psychiatric Care
☐ Radiation - Location:_____
☐ Rheumatic Fever
☐ Heart Attack
☐ Sinus Problems
☐ Stroke
☐ Thyroid Disease
☐ Other: _____