OLD BETSY
DENTAL
OF KEENE

PATIENT INFORMATION

Last Name:_______________________ First Name:_______________________ Middle Initial:_______

Gender: M / F Date of Birth:________ SSN:___________ Driver's License #:_________ Married: Y / N

Street Address:____________________________ City:_____________ State:_____ Zip:____________

Email:_______________________ Home Phone:________________ Cell Phone:___________________

Employer Name:_______________________________ Employer Phone:___________________________

Emergency Contact:________________________________ Emergency Phone:_____________________

How did you hear about our office?____

What is your preferred pharmacy?____

RESPONSIBLE PARTY

If the patient is under 18 years old, please complete the following:

Last Name:_______________________ First Name:_______________________ Middle Initial:_______

Date of Birth:________ Gender: M / F Married: Y / N SSN:_______ Driver's License #:___________

Email Address:______________________ Home Phone:____________ Cell Phone:________________

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name:_____________________________ Subscriber ID #:__________________________

Insurance Company:______________ Subscriber SSN:___________ DOB:________ Phone:_________

Employer:______________________ Group Name:___________________ Group #:_______________

INSURANCE POLICY 2

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name:_____________________________ Subscriber ID #:__________________________

Insurance Company:______________ Subscriber SSN:___________ DOB:________ Phone:_________

Employer:______________________ Group Name:___________________ Group #:_______________

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MEDICAL HISTORY

Name of Medical Doctor:____________________________ City/State:_____________________________

List any medications you are now taking:
[ ] None
____
____
____
____

Check medications you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/Other Narcotics
[ ] Erythromycin
[ ] Latex rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other:

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain upon Exertion
[ ] Damaged Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequent Dry Mouth
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Sleep Apnea/CPAP
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Other:___________________
[ ] Leukemia

Are you taking, or have you taken, bisphosphonates (e.g., Fosamax) for osteoporosis? Y / N
Tobacco use? Y / N If so, what kind and how much?____
Unusual reaction to dental injections?____
Women: Are you pregnant? Y / N Are you taking birth control pills? Y / N

DENTAL HEALTH

Reason for today's visit:______________________________________ Are you in pain? Y / N
Date of last dental visit:_______________________________________
Do you have your wisdom teeth? Y / N Are you missing any teeth?:______________________________
How happy are you with your smile? Choose 1-10: Not Happy 1 2 3 4 5 6 7 8 9 10 Very Happy
Do your gums bleed? Y / N Have you ever been diagnosed with sleep apnea? Y / N

By signing below, I certify that all of the above information is true to the best of my knowledge.

Signature:____

Date:_____________________________

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