DUBOIS DENTISTRY

ASA: I II III IV V

FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Other

Social Security #: _____ Driver's License: _____

Date of Birth : _____ Age: _____

Address: _____
Street Apt/Unit #

_____
City State Zip Code

Phone: _____ Email: _____

What is your preferred method of contact? (select all that apply)
□ Text □ Email □ Phone Call

Emergency Contact Information

Full Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Name of Insured: _____ Is insured a patient: □ **Yes** □ **No**
Last First MI

Insured's D.O.B.: _____ Insured's Employer Name: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other _____

Insurance Company Name: _____ Member I.D. # _____

Group # _____ Insurance Company Phone # _____

Health Information

Please take a moment to let us know your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? □ Yes □ No

- Have you been admitted to a hospital or needed emergency care during the past two years? **□ Yes □ No**

  If yes, please explain: _____

- Are you currently under the care of a physician: **□ Yes □ No**

  If yes, please explain:

  _____

- Name of Physician: _____ Phone: _____

  Address: _____
  Street Apt/Unit #

  _____
  City State Zip Code

Have you ever had any of the following? Please check all that apply:

□ Allergies (check all that apply): □ Seasonal □ Nuts □ Shellfish/Seafood □ Metals □ Latex □ Codeine □ Penicillin **□ Allergy to Medications: _____ □ Other:**				
□ Anemia	**□ Glaucoma**	**□ Arthritis**	**□ Asthma**	**□ Blood Thinners**
□ Heart Disease	**□ Liver Disease**	**□ Kidney Disease**	**□ Autoimmune Disease (ie, Lupus)**	**□ Blood Disease**
□ Thyroid Disease	**□ Neurological Disorders**	**□ Respiratory Problems**	**□ Mental Disorders**	**□ Digestive or eating disorder**
□ Prolonged Bleeding	**□ Viral infections, oral lesions, ulcers**	**□ Hives/rash/hay fever**	**□ Epilepsy or Seizures**	**□ Breathing or sleeping problems**
□ Cancer	**□ Radiation Treatment**	**□ Chemotherapy**	**□ Growth or Tumors**	**□ Tuberculosis**
□ Head or neck injuries	**□ Sinus problems**	**□ Dizziness or fainting**	**□ Calcium deficiency**	**□ Jaundice**
□ Smoker	**□ Pneumonia, Emphysema**	**□ Rhematic or Scarlet fever**	**□ Hormone deficiency**	**□ HIV/AIDS**
□ Heart Murmur	**□ Pacemaker**	**□ Stroke**	**□ Hepatitis** If yes, what type → □ A □ B □ C □ Non-AB	
□ Artificial/Prosthetic Joints If yes → □ Knee □ Hip □ Shoulder □ Titanium Plates □ Other Orthopedic Surgeon: _____ Doctor/s Full Name Phone Number				
□ Diabetes Type: _____	**□ High Cholesterol**	**□ High blood pressure**	**□ Pregnant?** If yes → Due date: _____	
Medications:				