

PATIENT INFORMATION

Welcome to Mobile Dentistry of California! 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 _____
 Home phone _____ Work phone _____
 Mailing address _____ City _____ State _____ Zip _____
 Employer _____ Occupation _____
 POA's name and relationship _____ POA's Number and email _____
 Whom may we thank for referring you to our office? _____ Internet
BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance
 Your Social Security number: _____ Dental Insurance Co. _____ Group number _____
 Covered by spouse's insurance? yes no
 Spouse's dental insurance company _____ Group number _____
 Spouse's birthday _____ Social Security number _____

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 prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing 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
- 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 diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- LIST ALL MEDICATIONS:** _____

Women:

- May be pregnant
- Taking hormones or contraceptives

Name of your physician and phone number: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Signature of patient (or POA) _____ Date _____