ROOSEVELT
DENTAL CENTER

PATIENT INFORMATION

Patient Name ____________ Date of Birth ____________ Sex ____ Age ____ M S W D ____

Street Address ____________ City ____________ State ____________ Zip ____________

Billing Address (if different) ____________ City ____________ State ____________ Zip ____________

Home Telephone # ____________ Patient Social Security # ____________ Driver License #/State ____________

Employer ____________ Employer Telephone # ____________ Mobile Phone # (optional) ____________

Name of Parent/Guardian (if applicable) ____________ Date of Birth ____________ Social Security # ____________

Emergency Contact Name and Phone # ____________

Primary Dental Insurance ____________ Group # ____________

Secondary Dental Insurance ____________ Group # ____________

Subscriber’s Name ____________ Date of Birth ____________ Social Security # ____________

How did you hear about us? ____

Dental Health History

Are you apprehensive about dental treatment? Y☐ N☐
Do you gag easily? Y☐ N☐
Are you unhappy with the appearance of your teeth? Y☐ N☐
Do you want your teeth to be whiter? Y☐ N☐
Have you ever had any complications following dental treatment? Y☐ N☐

Medical Health History

Physician Name and Phone Number ____

Do you or have you ever regularly used tobacco products? (cigarettes, chewing tobacco, pipes) Y☐ N☐

Do you have any allergies to any medications or latex products? Y☐ N☐

If yes, please list: ____

Do you have any of the following conditions?

☐ High Blood Pressure
☐ Diabetes
☐ HIV/AIDS
☐ Tuberculosis
☐ Joint Replacement
☐ Chest Pains
☐ History of Fosamax Treatment (or other osteoporosis medication)
☐ History of Heart Attack or Stroke
☐ Rheumatic Heart Fever
☐ Hepatitis
☐ Heart Disease
☐ Cancer Treatment
☐ Bleeding Disorder
☐Asthma
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Lung Problems
☐ Epilepsy or Seizures
☐ Thyroid Disorder
☐ Headaches/Migraines

Are you taking any medications or herbal supplements? ☐Y ☐N

If yes, please list:
____

Women Only: Are you pregnant? ☐Y ☐N

Do you have any other illness, condition, or problem not listed above? ☐Y ☐N

If yes, please describe briefly: __________________________________

{Staff Only} Blood Pressure: _______________ Dentist Initials: ____________