Welcome to Grateful Dental of Geneva

PATIENT INFORMATION

To assist us in serving you, please complete the following confidential form.

Patient's Name_____ Preferred Name_____ Birth Date_____
If minor, parents names_____Home phone _____Work phone_____
Mailing address_____City_____State_____Zip_____
Emergency Contact_____ Phone #_____
Name of Employer_____
How did you hear about our office? _____

INSURANCE INFORMATION: ☐ Not covered by dental insurance
Name of Subscriber:_____ Subscriber Social Security # _____Subscriber Birth Date_____
Please provide insurance card so copy can be made

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 lung problems
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurological 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
- ☐ Hay fever 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
- ☐ Other:_____
  _____

Women:

- ☐ May be pregnant
  Expected delivery date: _____
- ☐ Taking Hormones or contraceptives

Name of your physician: _____

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 parent)_____ Date_____