

**Corporate Center Dental Care  
Patient Information and Health History Form**

**Contact Information**

Patient Name (First, Middle, Last): \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work # (if child, Parent's): ( ) \_\_\_\_\_

Cell #: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_

Employer (Name, Address): \_\_\_\_\_

Parent or Guardian (if child): \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_

Spouse Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse Social Security # (for insurance purposes only): \_\_\_\_\_

In case of Emergency, please contact:

Name \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

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Would you like to be reminded of appointments by text message or email?

\_\_\_\_\_ Text Cell #: \_\_\_\_\_

\_\_\_\_\_ Email Email Address: \_\_\_\_\_  
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**DENTAL Insurance Information**

(Please provide our office with a copy of you insurance card)

Primary Insurance Company: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Date of Birth (Policy Holder): \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Date of Birth (Policy Holder): \_\_\_\_\_  
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How did you find out about our office? (Check all that apply)

Patient \_\_\_\_\_ Patient Name: \_\_\_\_\_

Doctor \_\_\_\_\_ Doctor Name: \_\_\_\_\_

TV \_\_\_\_\_ GiftCard \_\_\_\_\_ Internet \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Radio \_\_\_\_\_ Brochure \_\_\_\_\_

Magazine \_\_\_\_\_ Other \_\_\_\_\_

Are you interested in receiving information about any of the services below? (Please check all that apply)

Bleaching (tooth whitening) \_\_\_\_\_

Implants \_\_\_\_\_

BOTOX/Juvaderm \_\_\_\_\_

Porcelain Veneers/Lumineers \_\_\_\_\_

Invisalign (clear braces) \_\_\_\_\_

Sedation Dentistry \_\_\_\_\_

**Health History**

Date of last medical exam: \_\_\_\_\_ What was this exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, reason for hospitalization: \_\_\_\_\_

Are you currently receiving care? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, nature of care: \_\_\_\_\_

Please list the names/phone numbers of the physicians who are currently providing you care:

- 1.) \_\_\_\_\_ Phone #: \_\_\_\_\_
- 2.) \_\_\_\_\_ Phone #: \_\_\_\_\_
- 3.) \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have or have you had any of the following medical conditions? (Please check yes or no)

Heart Murmur	Yes _____ No _____	Liver Disease (including Jaundice)	Yes _____ No _____
Epilepsy	Yes _____ No _____	Hepatitis, any form	Yes _____ No _____
Rheumatic Fever	Yes _____ No _____	Abnormal Heart Condition	Yes _____ No _____
Asthma	Yes _____ No _____	HIV Positive or AIDS Related Complex	Yes _____ No _____
Kidney Disease	Yes _____ No _____	Emphysema or other Respiratory Illnesses	Yes _____ No _____
Psychosis	Yes _____ No _____	Sexually Transmitted Disease	Yes _____ No _____
Previous Biopsies	Yes _____ No _____	Sore/Enlarged Lymph Nodes	Yes _____ No _____
Glaucoma	Yes _____ No _____	Abnormal bleeding from a cut	Yes _____ No _____
Anemia	Yes _____ No _____	Slow healing mouth sores	Yes _____ No _____
Recurrent Illnesses	Yes _____ No _____	Snoring or Sleep Apnea	Yes _____ No _____
Diabetes	Yes _____ No _____ (HgA1C: _____)	Other Infections	Yes _____ No _____
Joint Replacement	Yes _____ No _____ (area and date of replacement: _____)		
Abnormal Blood Pressure	Yes _____ No _____ (what is it usually? S _____/D _____)		

Do you have a medical condition that requires you to pre-medicate with antibiotics before dental treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you allergic to any medications/drugs? Penicillin \_\_\_\_\_ Sulfa \_\_\_\_\_ Latex \_\_\_\_\_

Please list others: \_\_\_\_\_

Are you allergic to or have you ever had any unusual reactions to local anesthetic? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list any medications you are currently taking:

- 1.) \_\_\_\_\_
- 2.) \_\_\_\_\_
- 3.) \_\_\_\_\_
- 4.) \_\_\_\_\_
- 5.) \_\_\_\_\_
- 6.) \_\_\_\_\_
- 7.) \_\_\_\_\_
- 8.) \_\_\_\_\_

Are you taking any Antacids? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, how often? \_\_\_\_\_)

Are you taking Tagamet (Cimetidine)? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, how often? \_\_\_\_\_)

Are you taking any herbal supplements/medications? Yes \_\_\_\_\_ No \_\_\_\_\_  
(If yes, which ones? \_\_\_\_\_)

Are you a smoker? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, how much per day? \_\_\_\_\_)

Women: Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you planning a pregnancy in the next 6 months? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

