GibbsDentistry
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Patient Information:

Name_____ Preferred Name_____

Date of Birth_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Employer_____

Emergency Contact_____ Phone Number_____

Communication Preference: ☐ E-Mail ☐ Text

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Parent/Guardian Information:

Name_____ Relationship_____

Date of Birth_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Employer_____

Responsible Party:

Name_____ Relationship_____

Date of Birth_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Employer_____

Dental Insurance:

Primary Dental Insurance _____ Policy Holder_____

Date of Birth_____ SS Number_____Employer_____

Secondary Dental Insurance_____ Policy Holder_____

Date of Birth_____ SS Number_____Employer_____

Physician_____ Phone Number_____

Pharmacy_____ Phone Number_____

Signature of Patient, Parent or Guardian_____ Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If Yes_____

Have you every been hospitalized or had a major operation? O Yes O No If Yes_____

Have you ever had a serious head or neck injury? O Yes O No If Yes_____

Are you taking any medications, pills, or drugs? O Yes O No If Yes_____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No If Yes_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? O Yes O No If Yes_____

Are you on a special diet? O Yes O No

Do you use tobacco? O Yes O No

Women: O Pregnant/Trying to get pregnant O Nursing O Taking oral contraceptives

Are you allergic to any of the following:

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Sulfa Drugs O Local Anesthetics

Other? O Yes O No If Yes_____

Do you use controlled substances: O Yes O No If Yes_____

Do you have, or have you had any of the following? **Check all that apply.**

AIDS/HIV Positive		Cortisone Medicine		Hemophilia		Radiation Treatments	
Alzheimer's Disease		Diabetes		Hepatitis A		Recent Weight Loss	
Anaphylaxis		Drug Addiction		Hepatitis B or C		Renal Dialysis	
Anemia		Easily Winded		Herpes		Rheumatic Fever	
Angina		Emphysema		High Blood Pressure		Rheumatism	
Arthritis Gout		Epilepsy or Seizures		High Cholesterol		Scarlet Fever	
Artificial Heart Valve		Excessive Bleeding		Hives or Rash		Shingles	
Artificial Joint		Excessive Thirst		Hypoglycemia		Sickle Cell Disease	
Asthma		Fainting Spells/Dizziness		Irregular Heartbeat		Sinus Trouble	
Blood Disease		Frequent Cough		Kidney Problems		Spina Bifida	
Blood Transfusion		Frequent Diarrhea		Leukemia		Stomach/Intestinal Disease	
Breathing Problems		Frequent Headaches		Liver Disease		Stroke	
Bruise Easily		Genital Herpes		Low Blood Pressure		Swelling of Limbs	
Cancer		Glaucoma		Lung Disease		Thyroid Disease	
Chemotherapy		Hay Fever		Mitral Valve Prolapse		Tonsillitis	
Chest Pains		Heart Attack/Failure		Osteoporosis		Tuberculosis	
Cold Sores/Fever Blisters		Heart Murmur		Pain in Jaw Joints		Tumors or Growths	
Congenital Heart Disorder		Heart Pacemaker		Parathyroid Disease		Ulcers	
Convulsions		Heart Trouble/Disease		Psychiatric Care		Venereal Disease	
						Yellow Jaundice	

Have you ever had any serious illness not listed? O Yes O No If Yes_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian_____ Date_____