PUGH FAMILY DENTAL

Patient Information Form

Patient's Name_____ Date of Birth ____/____/____

Name of Spouse _____

Home Phone ( )_____ Cell ( )_____

Address _____ City/State/Zip_____

Social Security Number_____E-Mail_____

Patient Employed By_____ Work Phone _____

Spouse Employed By_____ Work Phone _____

Dental Insurance Information: NO YES--> If yes, give insurance card to front desk*

How did you hear about our office? _____

Health History

Please **CIRCLE** Your Response To Indicate If You Have Or Have Not Had Any Of The Following:

Heart Murmur/Mitral Valve Prolapse	No Yes	Psychosis	No Yes
Anemia	No Yes	Stroke	No Yes
Diabetes	No Yes	Previous Biopsies/Cancer	No Yes
Epilepsy	No Yes	Abnormal Blood Pressure	No Yes
Hepatitis (any form)	No Yes	Sore/Enlarged Lymph Nodes	No Yes
Rheumatic Fever	No Yes	Recurrent Illness	No Yes
Asthma	No Yes	Joint Replacement	No Yes
HIV/AIDS	No Yes	Sleep Apnea/ Sleep Disorder	No Yes
Abnormal Heart Condition	No Yes	Blood Thinner	No Yes
Kidney Disease	No Yes	Unintentional Weight loss/gain	No Yes
Heart (surgery,disease,attack)	No Yes	Latex sensitivity	No Yes
Herpes	No Yes	Liver Disease (including Jaundice)	No Yes
Bisphosphonates (osteoporosis)	No Yes		

- Are you required to pre-medicate before dental treatment? No Yes
- Are you Allergic to:
  - Penicillin : No Yes Other Antibiotics: No Yes _____
  - Local Anesthetics: No Yes Other:_____
- Are you a smoker? No Yes
- **Women**: Are you currently pregnant? No Yes Are you nursing? No Yes

Are you taking birth control pills No Yes

Please list all current medications below: