Welcome to

Adobe Dentistry

PATIENT INFORMATION AND HEALTH HISTORY

PATIENT'S NAME Last_____First_____MI____BIRTHDATE_____ SSN_____
ADDRESS_____State_____ZIP_____
PREFERRED PRONOUNS_____ E-MAIL ADDRESS _____
PHONE(h)_____ (c)_____(w)_____
EMPLOYER_____ OCCUPATION _____
SPOUSE/PARTNER'S NAME_____ REFERRED BY _____

PRIMARY INSURANCE

SUBSCRIBER_____RELATIONSHIP TO PATIENT_____ BIRTHDATE_____
EMPLOYER_____INS CO_____INS CO PHONE _____
MEMBER ID_____ SS#_____

SECONDARY INSURANCE

SUBSCRIBER_____RELATIONSHIP TO PATIENT_____BIRTHDATE_____
EMPLOYER_____INS CO_____INS CO PHONE _____
MEMBER ID_____ SS#_____

MEDICAL/DENTAL HISTORY

PLEASE MARK YES OR NO IF YOU HAVE HAD OR PRESENTLY HAVE ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Anemia	_____	_____	HIV	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Artificial Heart Valves	_____	_____	Jaw Pain	_____	_____
Artificial Joints	_____	_____	Kidney or Liver Disease	_____	_____
Cancer (Chemo or Radiation)	_____	_____	Diabetes	_____	_____
Respiratory Disease (Asthma)	_____	_____	Epilepsy	_____	_____
Rheumatic/Scarlet Fever	_____	_____	Food/Material Allergies (Latex?)	_____	_____
Headaches	_____	_____	Heart Problems/Surgery	_____	_____
Hemophilia	_____	_____	Hepatitis	_____	_____
Stroke	_____	_____	Surgical Implant	_____	_____
Thyroid Disease	_____	_____	Tuberculosis	_____	_____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSLY TO ANY OF THE FOLLOWING MEDICATIONS?

ASPIRIN Yes No LOCAL ANESTHETIC Yes No PENICILLIN Yes No CLINDAMYCIN Yes No

TYLENOL Yes No IBUPROFEN/ADVIL Yes No CODEINE Yes No

ARE THERE OTHER MEDICATIONS OR SUBSTANCES YOU MAY BE ALLERGIC TO?_____
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____
ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT?_____
HAVE YOU EVER TAKEN BISPHOSPHONATE DRUGS (TYPICALLY FOR OSTEOPOROSIS)?_____
DO YOU USE ANY TOBACCO PRODUCTS?_____
ANY RECENT SURGERIES OR OTHER SIGNIFICANT HEALTH ISSUES?_____
PHYSICIAN NAME_____ PHONE #_____
LAST DENTAL VISIT?_____ LAST FULL SET OF XRAYS?_____ LAST CLEANING?_____
DO YOU HAVE ANY SPECIFIC CONCERNS OR PROBLEMS WITH YOUR TEETH?_____
_____
HOW DO YOU FEEL ABOUT YOUR TEETH?_____
IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION THAT YOU FEEL I SHOULD KNOW ABOUT?_____
_____

Patient Signature (or guardian) _____ Date: _____

Dentist Signature_____