PatriotDental

Dr. Andrew Ducote, D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

Please complete both sides of this form to the best of your abilities. (PLEASE PRINT)

Patient's Name _____ Preferred Name _____

Date of Birth _____ Soc. Sec. # _____ Email _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Spouse's Name _____ Employer _____ Contact # _____

Emergency Contact Person: _____ Phone # _____

Whom May We Thank for referring you? ☐ Friend/Family _____ ☐ Insurance ☐ Bing

☐ Google ☐ Drive-By ☐ Yelp ☐ Website ☐ Other _____

If the patient is not responsible for payment of this account please complete the following information:

RESPONSIBLE PARTY

Responsible Person's Name _____

Home Address _____

Relationship to Patient _____ Soc. Sec. # _____ DOB _____

Home Phone _____ Work Phone _____ Alternative Phone _____

Employer _____ Address _____

INSURANCE INFORMATION

Policy Holder's Name _____ S.S.# _____ DOB _____

Employer _____ Address _____ Work# _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Policy ID # _____ Group # _____

X_____ _____

Signature of Patient or Parent/Guardian if Minor Date

PATIENT MEDICAL HISTORY

Patient Name _____ DOB _____ Date _____

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

Are you in good health? **Y** **N**

Have there been any changes in your general health within the past year? **Y** **N**

Are you now under the care of a Physician? **Y** **N**

Have you ever been hospitalized for any surgical operation or serious illness? **Y** **N**
_____
_____
_____

Are you taking any medications? **Y** **N**

If yes, what medications are you taking: _____
_____

Have you had any abnormal bleeding? **Y** **N**

Do you bruise easy? **Y** **N**

Date of your last physical exam: _____
Physician's Name: _____
Address: _____
Phone: _____

Date of your last dental treatment or cleaning. _____

What do you like best about your teeth? _____

What do you like least about your teeth? _____

What would you change about your teeth? _____

Do you have any of the following?

Gum Disease	Halitosis	Bruxism	Abscesses
Sensitivities	TMJ	Ulcers	Cold Sores
Pain in Jaw			

Are you currently experiencing a toothache or pain? **Y** **N**

Are there any other conditions which we should be aware of? **Y** **N**
Please explain: _____
_____

WOMEN ONLY

Are you pregnant or think you may be pregnant? **Y** **N**

Are you nursing? **Y** **N**

Are you taking birth control pills? _____ **Y** **N**

Are you allergic to or have you had reactions to:

Aspirin_____ Penicillin_____ Codeine_____ Novocaine_____ Metal_____ Latex Rubber_____
Local Anesthetics_____ Iodine_____ Sulfa drugs_____ Barbiturates or sleeping pills_____

Do you now have or have you ever had any of the following? Please check if appropriate.

☐ Heart Murmur	☐ Stroke	☐ Hemophilia	☐ Tumors/Growth	☐ Liver Disease	☐ Venereal Disease
☐ Pacemaker	☐ Leukemia	☐ Emphysema	☐ Hepatitis A, B or C	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Heart Surgery	☐ Cancer	☐ Kidney Disease	☐ Stomach Ulcer	☐ Lung Disease	☐ Low Blood Pressure
☐ Heart Trouble	☐ Blood Disease	☐ Thyroid Problems	☐ Breathing Problems	☐ Immune Deficiencies	☐ TMJ
☐ Artificial Heart Valve	☐ Artificial Joint	☐ Anemia	☐ Asthma	☐ Diabetes	☐ HIV Positive
☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Epilepsy/Seizure	☐ Psychiatric Care	☐ Tuberculosis	☐ Sinus Trouble

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the Dentist and staff at the next appointment without fail. I will not hold my Dentist or any staff members responsible for any errors or omissions that I may have made in the completion of this form

X _____ **Date** _____
(Patient signature / Parent or Guardian signature)

Reviewed by Dentist _____ Date _____ BP _____

History Reviewed and Significant Findings _____
_____
_____
_____