PATIENT INFORMATION

FISHER DENTAL

TREAVOR FISHER, DDS, LLC

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

PATIENT'S NAME________________________ PREFERRED NAME______________ BIRTH DATE__________

If minor, parents names________________________ HOME PHONE______________ WORK PHONE____________

MAILING ADDRESS________________________ CITY______________ STATE________ ZIP____________

EMPLOYER________________________ OCCUPATION________________________

SPOUSE'S NAME________________________ SPOUSE'S EMPLOYER________________________

Whom may we thank for referring you to our office?________________________

PRIMARY INSURANCE: ☐Not covered NAME OF INSURED______________ DATE OF BIRTH______________

SOCIAL SECURITY NUMBER______________ INSURANCE CO.______________ GROUP NUMBER______________

SECONDARY INSURANCE: (If applicable) NAME OF INSURED______________ DATE OF BIRTH______________

SOCIAL SECURITY NUMBER______________ INSURANCE CO.______________ GROUP NUMBER______________

Why do we need your social security number? *We will need your social security number when we contact your insurance company. Your personal information will never be sold to a third party or distributed outside our office.*

EMERGENCY CONTACT:______________ RELATIONSHIP______________ PHONE NUMBER______________

DENTAL HISTORY

What is the reason for your visit today? ________________________

When was your last dental exam and cleaning? ________________________

When were your last x-rays taken? ________________________

Are you experiencing any pain or sensitivity at this time? YES NO

If YES, please explain: ________________________

Do you clench or grind your teeth? YES NO

Do your gums bleed when you brush or floss? YES NO

Have you ever been prescribed an antibiotic pre-med for dental appointments? YES NO

How many times per day do you brush? ______ Floss? ______

Have you ever had any issues associated with previous dental treatment? YES NO

If YES, please explain: ________________________

Are you happy with the appearance of your teeth/smile? YES NO

If NO, please explain: ________________________

How would you rate your level of dental anxiety? None / Slight / Moderate / High / May Need Sedation

Do you have any other dental concerns you would like to have addressed? YES NO

if YES, please explain: ________________________

Patient (Guardian) Signature: **Date:**

MEDICAL HEALTH HISTORY

Name: ______________________________ **DOB:**___________

Please answer the following questions to the best of your ability. True and accurate answers are vital to allow us to provide appropriate care for you. As required by law, all answers will be kept confidential.

How would you rate your overall general health? EXCELLENT / GOOD / FAIR / POOR

Are you currently under the care of a physician? YES NO

If YES: Physician's Name: ______________________________ City:___________ Phone Number: _____________

Has there been any changes in your general health in the past year? YES NO

If YES, please explain: ____

Have you had any serious illnesses, surgeries, or hospitalizations in the past 5 years? YES NO

If YES, please explain: ____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

HEAD
- ☐Vertigo
- ☐Sinus Problems
- ☐Stroke/TIA
- ☐Seizures/Epilepsy
- ☐Fainting/Dizziness
- ☐Dementia
- ☐Cold sores or Canker sores
- ☐Other:___________________

HEART
- ☐High/Low Blood Pressure
- ☐Congestive Heart Failure
- ☐Congenital Heart Disease
- ☐Rheumatic Fever
- ☐Artificial (prosthetic) heart valve
- ☐Chest pain / Angina
- ☐Chest Pain / Angina
- ☐Heart Attack
- ☐Pacemaker / Defibrillator
- ☐Infective Endocarditis
- ☐Other:___________________

LUNGS
- ☐Asthma
- ☐Emphysema
- ☐Pneumonia
- ☐Tuberculosis

LIVER/KIDNEYS
- ☐Hepatitis or Liver Disease
- ☐Cirrhosis
- ☐Kidney Dialysis
- ☐Renal Failure
- ☐Other:___________________

DIGESTIVE SYSTEM
- ☐Ulcers / Stomach problems
- ☐GI Bleeding
- ☐Gastric Reflux / GERD
- ☐Other:___________________

HORMONES/IMMUNE SYS.
- ☐Diabetes
- ☐Lupus
- ☐Thyroid Disease
- ☐HIV / AIDS
- ☐Recurring Infections
- ☐Other:___________________

MUSCLE / SKELETAL
- ☐Artificial Joint(s)
- ☐Arthritis / Rheumatism
- ☐Multiple Sclerosis (MS)
- ☐Osteoporosis
- ☐Other:___________________

OTHER
- ☐Cancer or related treatment
- ☐Radiation Therapy
- ☐Organ Transplant
- ☐Bleeding Disorders
- ☐Tobacco
- ☐Alcohol
- ☐Recreational Drugs

WOMEN ONLY
- ☐Birth Control
- ☐Pregnant
- ☐Nursing

Please list and explain any other conditions not listed, or if you have any specific medical concerns:___________________________

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MEDICATIONS

Please list all medications and dietary supplements you have taken in the last 3 months. Include dosages and frequency. ***If you have a printed list of medications, we can scan a copy into your patient chart.***

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ALLERGIES

Please check any substances you've experienced an allergic or adverse reaction to. ***Please use the space provided to explain the reaction, if necessary.***

- ☐Local anesthetics:______________________________
- ☐Epinephrine:______________________________
- ☐Aspirin:______________________________
- ☐Penicillin or other antibiotics:______________________________
- ☐Sulfa Drugs:______________________________
- ☐Codeine or other narcotics:______________________________
- ☐Latex/rubber:______________________________
- ☐Iodine:______________________________
- ☐Other:______________________________

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Patient (Guardian) Signature: **Date:**