

PATIENT INFORMATION FORM

TODAY'S DATE: ____/____/____

NAME:(Dr /Mr /Miss /Mrs /Ms) _____
(Please Circle) (First) (MI) (Last)

NICKNAME/PREFERRED NAME: _____

ADDRESS: _____
(Street) (City/State) (Zip)

ALTERNATE ADDRESS: _____
(Street) (City/State) (Zip)

HOME PHONE:(____) _____ WORK PHONE:(____) _____

ALTERNATE PHONE:(____) _____ FAX:(____) _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: ____/____/____ AGE: _____ GENDER: MALE / FEMALE
(Please Circle)

REFERRED BY: _____ GENERAL DENTIST: _____

What is the reason for your initial visit in our office? _____

OCCUPATION: _____

EMPLOYER NAME & ADDRESS: _____

Does your work environment routinely expose you to x-rays or ionizing radiation?..... Yes No

PHYSICIAN NAME & CITY: _____ PHONE:(____) _____

Are you currently under the care of a physician? (incl. cardiologist/hematologist, etc)..... Yes No

If yes, please explain: _____

When was your last physical examination? _____ Was anything unusual or abnormal found?..... Yes No

If yes, please explain: _____

Have you ever had any operations, hospitalizations or serious illness?..... Yes No

If yes, please explain: _____

PHARMACY NAME & LOCATION: _____ PHONE:(____) _____

GENERAL HEALTH QUESTIONNAIRE

PATIENT NAME: _____ DATE OF BIRTH ____/____/____ AGE ____

► Do you have or have you ever had:

	Yes	No		Yes	No
Rheumatic fever			Asthma		
Congenital heart disease			Bronchitis/chronic cough		
Mitral valve prolapse			Shortness of breath		
Heart murmur			Emphysema		
Heart valve replacement			Chronic Obstructive Pulmonary Disease		
Prosthetic (artificial joints)			Recurrent sore throat		
High cholesterol			Sleep Apnea		
Angina (chest pain)			Tuberculosis		
Irregular heart beat			Sinus problems		
Coronary artery disease			Thyroid disease		
Heart disease/Heart attack			Glaucoma		
Cardiac pacemaker			Kidney disease		
Swelling of the ankles			Liver disease/Hepatitis		
High or Low blood pressure			Diabetes		
Stroke/TIA			Ulcers or colitis		
Bleeding problems			Gastrointestinal problems		
Anemia			Arthritis/ Joint pain/ Back problems		
Hemophilia			Cancer		
Seizures/Epilepsy			Radiation/Chemotherapy treatments		
Dizziness/Fainting			TMJ symptoms/treatment		
Sexually transmitted disease			Prostate problems		
HIV/AIDS			Osteoporosis		

► Are you allergic to or have you had an adverse reaction to:

	Yes	No		Yes	No
Local anesthetics			Sedatives, barbiturates		
Penicillin/Amoxicillin			Codeine		
Sulfa drugs			Other narcotics		
Other antibiotics			Aspirin or Ibuprofen		
Iodine/Betadine/Neosporin			Latex or adhesive tape		

Please list additional allergies: _____

► Are you taking any of the following medications:

	Yes	No		Yes	No
Any type of blood thinners			Diuretics/Water pills		
Aspirin or Ibuprofen			Insulin or oral anti-diabetic drugs		
Coumadin			Blood pressure medicine		
Vitamin E			Prednisone/steroids		
Glucosamine			Medication for osteoporosis		

Please list all current medications: _____

GENERAL HEALTH QUESTIONNAIRE

Is there a past history of alcohol, chemical dependency, psychiatric treatment, nervous or emotional disorder that may affect the care we provide you?..... Yes No

Do you have a cold or cough at this time?..... Yes No How much do you weigh?_____

Do you drink alcoholic beverages?..... Yes No If yes, how much?_____

Do you smoke or chew tobacco?..... Yes No If yes, how much?_____

Have you or a member of your family ever had difficulty with, or a bad reaction to General Anesthesia?..... Yes No

If yes, please explain:_____

Have you ever been instructed to take antibiotics before dental treatment?..... Yes No

FEMALE PATIENT: Are you or could you be pregnant? Yes No
Are you taking birth control pills? Yes No
Are you nursing? Yes No

FOR YOUR INFORMATION
Antibiotics may interfere with the effectiveness of oral contraceptives.

Do you have any other disease, condition or problem not listed above that you think the Doctor should know about?..... Yes No

If yes, please list:_____

The disclosure of medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction or a major periodontal procedure. Your general health may have a significant affect on your current condition and on the outcome of any proposed treatment. For the good of your overall health and safety, please answer all questions.

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT:

X _____
Patient's Signature Date Parent/Guardian Signature (if minor)

DOCTOR'S REVIEW: ASSISTANT'S REVIEW:
▶ _____ ▶ _____
Doctor's Signature Date Assistant's Signature

Notice of Privacy Practices:

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available on-line: www.drryanaylor.com/Patient Forms. If you do not have internet connectivity, please ask one of our staff for a copy of our Notice.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
Patient's Signature (Parent/Guardian, if minor) Date