Welcome to

Adobe Dentistry

PATIENT INFORMATION AND HEALTH HISTORY

PATIENT'S NAME Last_____First_____MI____ BIRTHDATE_____
HOME ADDRESS_____ SOC SEC#_____
PREFERRED PRONOUNS_____ E-MAIL ADDRESS_____
PHONE(h)_____ (c)_____
DRIVER'S LICENSE#_____OCCUPATION_____EMPLOYED BY_____
BUSINESS ADDRESS_____WORK PHONE_____

PRIMARY INSURANCE HELD BY_____RELATIONSHIP TO PATIENT_____
PHONE(h)_____ BUS NAME/POLICY HOLDER_____
INSURANCE CO_____ EMPLOYEE ID_____ SS#_____

REFERRED BY_____ SPOUSE/PARTNER'S NAME_____
NAME/PHONE OF RELATIVE NOT LIVING WITH YOU_____

MEDICAL/DENTAL HISTORY

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

ANEMIA YES NO
ARTHITIS YES NO
ARTIFICIAL HEART VALVES YES NO
ARTIFICIAL JOINTS YES NO
CANCER(CHEMO OR RADIATION) YES NO
RESPIRATORY DISEASE(ASTHMA) YES NO
FOOD/MATERIAL ALLERGY(LATEX) YES NO
HEART PROBLEMS/SURGERY YES NO
HEPATITIS YES NO
SURGICAL IMPLANT YES NO
HIV YES NO
HIGH BLOOD PRESSURE YES NO
JAW PAIN YES NO
KIDNEY OR LIVER DISEASE YES NO
DIABETES YES NO
RHEUMATIC FEVER YES NO
HEADACHES YES NO
HEMOPHILIA YES NO
STROKE YES NO
TUBERCULOSIS YES NO

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

Aspirin Local Anesthetic Penicillin Clindamycin Tylenol
Ibuprofen/Advil Codeine

Are there any other medications or substances that 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 or vaping products?_____
Any recent surgeries or other significant health issues?_____
How long since your last dental visit?____ Last set of full mouth x-rays?_____ 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 _____