DAVID ROSS, DMD
J LAWRENCE EARL, DMD
FINE DENTISTRY

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Finedentistrynv.com

PATIENT INFORMATION

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_____
Person Responsible for account _____Cell phone _____ Home phone_____
Mailing address _____ City _____State _____ Zip_____
Email address_____
Employer _____Occupation _____
Spouse's name _____ Spouse's employer _____ ❑ Unmarried
If patient is a minor, who is the responsible party?_____
EMERGENCY CONTACT INFORMATION:
Who do we contact in case of emergency?_____
Relationship to patient?_____
How can we contact this person?_____
How did you first hear about us? ❑ By a Friend, who?_____ ❑ Mail ❑ Social Media ❑ Internet ❑ Online reviews ❑ Post card ❑ Saw our sign from the street ❑ Insurance Co ❑ A dream ❑ Direct contact ❑ Family member ❑ phone book

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance
Your Social Security number: _____ Dental Insurance Co._____
Group number_____ ID Number _____ Insurance Phone Number_____
Covered by spouse's insurance? ❑ yes ❑ no
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ Social Security number _____
ID Number _____ Insurance Phone Number _____

Signature of Patient or Parent if a Minor:_____ Date:_____

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MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ☐ Cancer or tumor
- ☐ Heart ailment
- ☐ Angina
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial heart valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis
- ☐ Lung problems
- ☐ Kidney disease
- ☐ Hepatitis and Type ____
- ☐ Liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures
- ☐ Fainting spells or dizziness
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Anemia
- ☐ Blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hayfever
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Stroke
- ☐ Back problems
- ☐ Chemical dependency or adiciton
- ☐ Gastric reflux disease
- ☐ Sinus trouble
- ☐ Hypoglycemia
- ☐ Glaucoma

Do you smoke or use chewing tobacco? ☐ yes ☐ no

Do you use medical marijuana? ☐ yes ☐ no

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics ("Novocain")
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other:_____

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other:_____

Women:

- ☐ Nursing
- ☐ May be pregnant Expected delivery date:_____

Please list current medications and purpose:_____

_____

Are you currently under the care of a physician?____ If yes why?_____

Name of your physician:_____ Pysician Phone Number_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date _____