Medical Information

Name _____

Other than your teeth, are you having pain or discomfort at this time? ..... YES NO
Have you been a patient in the hospital during the past two years? ..... YES NO
Have you been under the care of a medical doctor during the past two years? ... YES NO
Physician's Name & address _____ Phone _____

Medications

Please list any drugs or medications that you are currently taking, their purpose and the physician who prescribed them:

Drug	Purpose	Doctor

Indicate which of the following you have had or have at present. Circle YES or NO for each item.

Atrial Fibrillation.....	YES	NO	Osteoporosis Therapy ...	YES	NO	S.T.D.....	YES	NO
Heart Disease, Attack	YES	NO	Kidney Trouble.....	YES	NO	H.I.V Positive.....	YES	NO
Heart Surgery.....	YES	NO	Diabetes.....	YES	NO	A.I.D.S.	YES	NO
Chest Pain	YES	NO	Thyroid Problems.....	YES	NO	Cold Sores/Fever Blisters	YES	NO
Congenital Heart Diseae	YES	NO	Emphysema.....	YES	NO	Blood Transfusion.....	YES	NO
Congestive Heart Failure	YES	NO	Tuberculosis.....	YES	NO	Dialysis	YES	NO
Heart Murmur	YES	NO	Asthma.....	YES	NO	Hemophilia.....	YES	NO
High Blood Pressure.....	YES	NO	Smoke Cigarettes.....	YES	NO	Anemia.....	YES	NO
Mitral Valve Prolapse	YES	NO	Chew Tobacco	YES	NO	Sickle Cell Disease.....	YES	NO
Artificial Heart Valve.....	YES	NO	Hay Fever.....	YES	NO	Bruise Easily.....	YES	NO
Heart Pacemaker	YES	NO	Allergies or Hives.....	YES	NO	Liver Disease.....	YES	NO
Cortisone Medicine	YES	NO	Sinus Trouble.....	YES	NO	Yellow Jaundice.....	YES	NO
Rheumatic Fever	YES	NO	Cancer.....	YES	NO	Epilepsy or Seizures.....	YES	NO
Arthritis/Rheumatism.....	YES	NO	Tumors.....	YES	NO	Fainting or Dizzy Spells..	YES	NO
Stroke.....	YES	NO	Radiation Therapy.....	YES	NO	Nervousness/Anxiety.....	YES	NO
Artificial Joint	YES	NO	Chemotherapy.....	YES	NO	Anorexia/Bulimia.....	YES	NO
(Knee,Hip, etc.)			Hepatitis A, B or C.....	YES	NO	Psychiatric Care.....	YES	NO

Do you have or have you had any disease, condition or problem not listed? If so, please list:

_____

Do you have or have you had an allergy, unusual reaction or addiction to the following?

Aspirin.....	YES	NO	Cephalexin/Keflex	YES	NO	Codeine.....	YES	NO
Penicillin.....	YES	NO	Tetracycline.....	YES	NO	Vicodin/Norco.....	YES	NO
Amoxicillin.....	YES	NO	Other Antibiotics.....	YES	NO	Local Anesthetics.....	YES	NO
Ampicillin.....	YES	NO	Percocet.....	YES	NO	Sulfa Drugs.....	YES	NO
Cipro	YES	NO	Valium.....	YES	NO	Latex.....	YES	NO
						Other _____		

Are you taking birth control pills? YES NO
Are you Pregnant? ..... YES NO _____months Are you nursing?..... YES NO

_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's (or Guardian's) Signature _____ Date _____

Doctor's Signature _____

Comments/Updates:

Welcome to the office of

James D. Prigmore, DDS

Patient's Name _____ ***Date of Birth*** _____

Address _____ ***Social Security #*** _____

City _____ Zip code _____ ***Insurance I.D. #*** _____

E-mail address _____ Home Phone _____

Marital Status: S M D W Cell Phone _____

Minor patient's parent or guardian _____ Work Phone _____

If patient is full time student, name of school _____

Emergency contact _____ Relationship _____

Address _____ Phone # _____

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

Insurance & Responsible Party Information

Insured's Name _____ ***Date of Birth*** _____

Relationship to Patient: Self Spouse Parent Step-parent Other _____ ***SS#*** _____

Address _____ Home & Cell Phone _____

Employer _____ Work Phone _____

Insurance Company _____ ***Group #*** _____

Ins. Co. Address _____ Ins. Co. Phone _____

Name of Union _____ Local# _____ Union Phone _____

If you have dual insurance, please complete the following:

Insured's Name _____ ***Date of Birth*** _____

Relationship to Patient: Self Spouse Parent Step-parent Other _____ ***SS#*** _____

Employer _____ Phone _____

Insurance company _____ ***Group #*** _____

Name of Union _____ Local# _____ Union Phone _____

Dental Information

Do your gums bleed when you brush? YES NO

Do you have fear of dental work? YES NO

Do you grind or clench your teeth? YES NO

Are your teeth sensitive to sweets? YES NO

Are your teeth sensitive to pressure? YES NO

Are your teeth sensitive to heat and cold? YES NO

Are you suffering from pain or swelling in your mouth? YES NO

If you could change your smile, what would you do? _____

Date of last dental exam and/or cleaning: _____ Name of previous dentist: _____

What was done at your last dental appointment? _____

Why did you leave your last dentist? _____