

# Five Points

FAMILY DENTISTRY ●●●●●

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security#: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Contact Phone# \_\_\_\_\_ cell / home / work

Address: \_\_\_\_\_

Street

City

State

Zip Code

Email Address: \_\_\_\_\_

\_\_\_ Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_ Child \_\_\_ Other

**Has Insurance Changed** (circle one) YES / NO (If yes, explain) \_\_\_\_\_

**Future Billing Statements** (circle one) Email / Text / Mail \_\_\_\_\_

### Health History Please check those that apply

\_\_\_ AIDS/HIV Infection

\_\_\_ Acid Reflux

\_\_\_ Allergies: Type: \_\_\_\_\_

\_\_\_ Anemia

\_\_\_ Anxiety/Mental Disorder/Depression

\_\_\_ Artificial Joints: Date: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Asthma

\_\_\_ AutoImmune Disease: Type: \_\_\_\_\_

\_\_\_ Blood Disorder

\_\_\_ Bisphosphonate Use: (osteoporosis, cancer)  
(ex: Zometa, Reclast, Fosamax)

\_\_\_ Cataracts/ Glaucoma

\_\_\_ Cancer: When: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Cholesterol

\_\_\_ Cold Sores

\_\_\_ Diabetes

\_\_\_ Dizziness/ Fainting

\_\_\_ Epilepsy

\_\_\_ Excessive Bleeding

\_\_\_ Headaches/ Head Injury

\_\_\_ HPV

\_\_\_ Herpes: Type \_\_\_\_\_

\_\_\_ Heart Murmur/ Mitral Valve Prolapse

\_\_\_ Heart Problems: Type: \_\_\_\_\_

\_\_\_ Hepatitis: Type: \_\_\_\_\_

\_\_\_ High Blood Pressure

\_\_\_ Kidney Disease

\_\_\_ Liver Disease/ Jaundice

\_\_\_ Organ Transplant: When: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Premedicate w/ antibiotics

\_\_\_ Penicillin Allergy

\_\_\_ Pacemaker

\_\_\_ Radiation Treatment

\_\_\_ Respiratory Problems

\_\_\_ Sinus Problems

\_\_\_ Stomach Problems

\_\_\_ Stroke: When: \_\_\_\_\_

\_\_\_ TOBACCO Use

\_\_\_ Thyroid Disorder

\_\_\_ Tuberculosis

\_\_\_ Ulcers

\_\_\_ Current Pregnancy: Due Date: \_\_\_\_\_

**\* COVID 19 FULLY VACCINATED YES / NO**

**Are you allergic to latex?** YES / NO

**Are you currently taking blood thinners?** YES / NO

Describe any other health problems not listed above: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Have you ever had any complications following past dental treatments? YES / NO

If yes, Explain: \_\_\_\_\_

Medical Physician : \_\_\_\_\_ Phone: \_\_\_\_\_

I have reviewed and accept the terms of the Privacy Act (HIPAA)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_