CHART NO. _____

ANY UPDATES?

We appreciate the confidence you have placed in us to provide you with oral health services. To assist us in serving you, please enter any changes to the form below. The information provided is very important to your overall wellness. If you have any questions, please don't hesitate to ask.

Dental Health Colorado

Personal Information

Name _____ DOB / / Age Sex
First Middle Last
Address _____ City _____ State Zip

Cellphone Home Phone Email

Employer Work Phone

Driver's License State SSN – –

Dental Insurance *(please provide card so we may scan it into your patient file)*

Insurance Provider Group Name

Subscriber (self or spouse) DOB / / ID #:
First Middle Last
Group ID Phone Number

Address City State Zip

Medical Health History

Primary Care Physician (PCP) Practice Name

Please check if you are sensitive or allergic to any of the following:

____Penicillin
____Codeine
____Barbiturates (sleeping pills, sedatives)
____Sulfa Drugs
____Demerol
____Novocaine or Other Dental Anesthetic
____Foods (please explain)_____
____Other (please explain)_____
____Other Antibiotic
____Aspirin

Please list all medications you are taking (use additional sheet if necessary)

Do you smoke or chew tobacco? Yes No Do you drink alcoholic beverages? Yes No

Please check if you have ever had any of the following:

____Heart Disease
____Heart Attack
____Stroke
____Heart Murmur
____Hemophilia
____Scarlet Fever
____Abnormal Blood Pressure (high/low)
____Severe or Frequent Headaches
____Fainting Spells
____Epilepsy
____Nervous Disorder or Psychiatric Care
____Ulcers
____Hepatitis, Liver Disease or Jaundice
____Artificial Transplants or Implants (Pacemaker, Heart Valve, Hip Joint, etc.)
____Rheumatic Fever
____Eye Disease (Glaucoma, Cataracts, etc.)
____Ear Trouble
____Sinus Trouble
____Lung Disease (T.B., Emphysema, etc.)
____Arthritis
____Kidney Disease or Infections
____Diabetes
____Blood Disorders (Anemia, Leukemia, etc.)
____Venereal Disease
____Skin Disease
____X-Ray, Radium or Cobalt Treatment
____Tumors or Malignancies
____Other
____AIDS

WOMEN ONLY

Are you Pregnant? No Yes Delivery Date
Taking oral contraceptives? No Yes
Are you or have you passed through Menopause? No Yes

Any other personal information or conditions not listed above?

Patient/Guardian Signature X **Today's Date** / /