Beth A. Loew, D.D.S.
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(614) 487-0112

PATIENT INFORMATION FORM

Today's Date: _____

Welcome…The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Name: _____ I prefer to be called: _____
LAST FIRST MI MR MRS MS DR

☐ Male ☐ Female Birth Date:_____ / _____ / _____ Age:_____ SS# _____

Home Address: _____
APT / CONDO # CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced Home #: _____ Pager / Cell #: _____

☐ Widowed ☐ Partnered WK #: _____ Ext _____ E-mail: _____

Employer:_____

Employer's Address: _____

Who may we Thank for referring you? _____ Other family members seen by us: _____

Previous / Present Dentist:* _____ Last Visit Date: _____
(PLEASE CIRCLE)

SPOUSE INFORMATION

Their Name: _____ Employer:_____

WK #: _____Ext_____SS# _____Birth Date_____ / _____ / _____ DL #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Person Responsible for Account: _____ WK #:_____ Ext _____

HM # _____ Billing Address: _____

Relationship: _____SS #: _____Employer: _____DL #_____

DENTAL INSURANCE

Primary Dental Insurance Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone #: _____Group # (Plan, local or Policy #):_____

Insured's Name: _____Relation: _____ Insured's Birth Date:_____ / _____ / _____

Insured's SS #: _____Insured's Employer: _____

Secondary Dental Insurance Insurance Co. Name: _____

Insurance Co. Address:_____

Insurance Co. Phone #: _____Group # (Plan, local or Policy #):_____

Insured's Name: _____Relation: _____ Insured's Birth Date:_____ / _____ / _____

Insured's SS #: _____Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation:_____

WK #: _____HM #:_____

over →

MEDICAL HISTORY

Do you have a preferred physician? ☐ No ☐ Yes Physician's Name: _____

Phone #: _____ Date of last visit: _____ **Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐ No ☐ Yes Please explain _____

_____

Are you taking daily **ANY** prescriptions / over-the-counter vitamins / supplements? ☐ No ☐ Yes

Please list _____

_____

Have you ever had any of the following diseases or medical conditions?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Heart Surgery / Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N High Cholesterol

Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe / Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Faint
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Gerd/Acid Reflux/Apnea/Wear CPAP(?)

Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Arthritis
Y N Asthma
Y N Difficulty Breathing
Y N Hospitalized for Any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema / Glaucoma
Y N Do you Chew Tobacco / Smoke
Y N Osteoporosis

Please list any recent surgeries or hospitalizations with dates.

_____

_____

Are you allergic to any drugs / foods?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs / foods that you are allergic to: _____

_____

Dental: How often do you brush? _____ How often do you floss? _____

Do your gums bleed? Y N Do you have tooth sensitivity? Y N

For Women

Are you taking birth control pills? ☐ No ☐ Yes Are you pregnant? ☐ No ☐ Yes

Week # _____ Are you nursing? ☐ No ☐ Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____ Date _____

Office Use Only

Medical History Review & Update

I have reviewed the medical / dental information above with the parent / guardian and patient named herein.

Date	Signature	Date	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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