AllSmiles Family Dentistry
Ilona K. Furman, D.D.S., P.S.

PATIENT CONFIDENTIAL INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name ______________________ Preferred name ______________ Birth date__________

If minor, parent's name ______________Home phone ______________ Cell phone ______________

Email address ______________________ Which way is easiest to contact you? ______________

Mailing address ______________________ City ______________State ________ Zip __________

Employer ______________________ Occupation ______________________

Spouse's name ______________________ Spouse's employer ______________________ ❑ Unmarried

How did you hear about our office? If referral, whom may we thank? ______________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: ______________ Dental Insurance Co.______________ Group number__________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________ Group number ______________

Spouse's birthday ______________ Social Security number ______________________

MEDICAL HEALTH HISTORY

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

- ❑ Cancer or tumor: ______________
- ❑ Snoring, waking up at night, possible sleep apnea
- ❑ Heart ailment, murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve ______________
- ❑ High or low *blood pressure*
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes, type _____
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition ______________
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no
Frequency per day? ______________

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics ______________
- ❑ Local anesthetics ("Novocaine")
- ❑ 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:

- ❑ May be pregnant
  Expected delivery date: ______________
- ❑ Taking hormones or contraceptives

Name of your physician: ______________________ Approximate date of last visit: ______________

Is there anything else you want to share?______________________

What is the reason you are seeing the dentist?______________________

Circle all that apply to you: Dark/stained teeth Grinding/Clenching Dental Anxiety Cavities Missing teeth Sensitivity

Signature of patient (or parent) ______________________ Date ______________