Swamp Rabbit Dental

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New Patient Information & Medical History

PATIENT INFORMATION

First:	M. (init)	Last:	Date of Birth: / /
SSN:		Mobile #:( ) -	text call email
Street Addr:		Home #: ( ) -	*Please circle how you would like to be contacted*
City:	ST: Zip:	email:	

DENTAL INSURANCE

Employer Name:	**Policy Holder Name** (if not patient)**:**
Ins Co. Name:	Member ID:
Ins Co. Mailing Addr:	SSN#:
City: ST: Zip:	Phone #:
Ins Co Phone: ( ) -	Street:
Payor ID: Group:	City: State: Zip:
Member ID:	Date of Birth: / /

MEDICAL HISTORY

AIDS/HIV	*Yes or No*	Heart Attack/Problems	*Yes or No*
Alcohol/Drug Abuse	*Yes or No*	Hepatitis (When_____)	*Yes or No / A B C*
Anemia	*Yes or No*	Herpes	*Yes or No*
Artificial Joint Replacement	*Yes or No*	Kidney Problems	*Yes or No*
Type:_____	*Pre-Med required?*_____	Mitral Valve Prolapse	*Yes or No*
Arthritis	*Yes or No*	Penicillin Allergy	*Yes or No*
Asthma	*Yes or No*	Pregnant (Due Date _____)	*Yes or No*
Blood Pressure	*High/Low/Normal*	Psychiatric care	*Yes or No*
Blood Thinners	*Yes or No*	Seizures	*Yes or No*
Cancer/Radiation/Chemo	*Yes or No*	Sickle Cell Anemia	*Yes or No*
Celiac/Gluten Allergy	*Yes or No*	Stomach Ulcer	*Yes or No*
Circulation Problems	*Yes or No*	Stroke	*Yes or No*
Codeine Allergy	*Yes or No*	TMJ	*Yes or No*
Diabetes	*Yes or No*	Tobacco	*Y or N - Smoke / Chew / Dip*
Excessive Bleeding	*Yes or No*	Tuberculosis	*Yes or No*
Fainting / Dizziness / Epilepsy	*Yes or No*	Drug Allergies	_____
Heart Murmur	*Yes or No*		

Primary Dr. Name:
Phone:

Emergency Contact:
Phone:
Relation:

Any Surgeries:

Medication list:

Allergies not listed:

Signature (Patient or Guardian): Date: / /

Print Name: