WILLIAM E. POOLE
FAMILY DENTISTRY

Caring Doctor • Friendly Team • Quality Care
EVERY TIME.

PATIENT INFORMATION

Today's Date _____ Birth Date _____

(Confidential)

First Name _____ MI _____ Last _____

SS# _____ ☐ Male ☐ Female Home Phone _____

Cell Phone _____ Email Address _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed

Patient's Employer _____ Work Phone _____

Person to contact in case of an emergency _____ Phone _____

If patient is a minor, please provide:

Mother's First Name _____ Mother's Last Name _____

Father's First Name _____ Father's Last Name _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY (if different than above)

Name of person responsible for this account: _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

DENTAL INSURANCE INFORMATION (fill out if applicable)

Name of Insured _____ Relationship to Patient _____

ID No. _____ Birth Date _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # Ins. Co. Address _____

City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No **If yes, complete the following:**

Name of Insured _____ Relationship to Patient _____

ID No. _____ Birth Date _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # Ins. Co. Address _____

City _____ State _____ Zip _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1) Are you under medical treatment now?	☐	☐
2) Have you ever been hospitalized for any surgical operation or serious illness? If yes, please list:	☐	☐

_____

_____

_____

_____

_____

	Yes	No
3) Are you taking any medications including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐

_____

_____

_____

_____

	Yes	No
4) Do you use tobacco?	☐	☐
5) Are you allergic to any medications suchas:		
a) Local anesthetics (e.g. Novocaine)	☐	☐
b) Penicillin or other antibiotics	☐	☐
c) Other allergies (Please List)	☐	☐

_____

_____

7) Women Only:

a) Are you pregnant or think	☐	☐
b) you may be pregnant?	☐	☐
c) Are you nursing?	☐	☐
d) Are you taking birth control pills?	☐	☐

8) Do you have any of the following?

Yes	No		Yes	No	
☐	☐	Joint replacement (hip, knee, etc.)	☐	☐	Asthma/Emphysema or other breathing problems
☐	☐	Cardiac pacemaker or defibrillator	☐	☐	AIDs or HIV Infection
☐	☐	High blood pressure	☐	☐	Thyroid Problem
☐	☐	Low blood pressure	☐	☐	Cancer
☐	☐	Heart attack or chest pain	☐	☐	Radiation Therapy or Chemotherapy
☐	☐	Heart murmur	☐	☐	Hepatitis/Jaundice or Liver Disease
☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Stroke	☐	☐	Sexually Transmitted Disease
☐	☐	Diabetes	☐	☐	Other Medical Problems or Diseases (Please List):
☐	☐	Rheumatic Fever			
☐	☐	Fainting/Seizures/Epilepsy			

_____

_____

PATIENT DENTAL HISTORY

1) What is the main reason for your visit today? _____

_____

2) Would you like to discuss options to improve your smile? ☐ Yes ☐ No

SIGNATURE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient, Parent or Guardian _____ **Today's Date** _____

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