HORTON & VRANAS D.D.S.

Chart #: __________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ **Date**:__________________
Last First MI (Preferred Name)

Gender: ☐ M ☐ F BirthDate:________Social Security #: _________________ ☐ Married ☐ Single ☐ Divorced ☐ *Widowed*

Phone Home: _______________ Work: ___________Ext: ___ Cell: _____________Spouse's Name:______________

Address:____
Street City State Zip Code

Employed By:__________________________________ **Insurance Change**: ☐ Yes ☐ No

Preferred Confirmation Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail ☐Text Msg

Email Address:_________________________________ **Referred By**_________________________________

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Artificial Heart Valves
☐ Artificial Joints
PlaceDate:______________
Type_________________

☐ AIDS/HIV
☐ Asthma
☐ Cancer
Type_________Year_____
Chemo_______
Radiation______
☐ Diabetes DietControlled_
Insulin Dependant____
☐ Anemia
☐ Epilepsy/Seizures
☐ Emphysema

☐ Fainting/Dizziness
☐ Heart Attack
☐ Cardiac Stent/Year__
☐ Heart Problems
☐ Pacemaker
☐ Hemophilia
☐ Hepatitis
☐ HighBloodPressure
☐ LowBloodPressure
☐ Tuberculosis
☐ Arthritis/ Rheumatism
☐ Back Problems
☐ Blood Disease
☐ Drug/Alcohol Abuse
☐ Cocaine Use
☐ CirculatoryProblems

☐ CortisoneTreatments
☐ Glaucoma
☐ Seizures
☐ Kidney Disease
☐ Liver Disease
☐ PsychiatricCare
☐ Stroke
☐ ThyroidProblems
☐ Ulcer(s)
☐ Headaches
☐ Venereal Disease

Allergies
☐ Amoxicillin Allergy
☐ Aspirin Allergy
☐ Codeine Allergy

☐ Dental Anesthetics
☐ Latex Allergy
☐ Penicillin Allergy
☐ Tetracycline Allergy
☐ Sulfa Drug Allergy
☐ Other Drug Allergies
____
____
____
____
____

Do you smoke? Yes/No How many per day? ______Do you use chewing tobacco? Yes/No

Are you or have you ever taken Bisphosphonate therapy drugs: ie: Actonel, Boniva, Fosamax or Didronel for osteoporosis or certain types of cancer? Yes / No

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ____

Name of Physician: ____ Phone: __________________________

Have you ever had a blood transfusion? Yes / No What year?_______

Are you pregnant? No / Yes What week?____ Are you nursing No / Yes Are you taking birth control pills? No / Yes

Are you currently taking any medications, including over- the-counter, ie: Aspirin, Advil, Herbs, and/or Vitamins?
No / Yes, if so for describe what condition:

List: ____
____

In Case of an emergency who should be notified? Name:___________________________________ **Phone**:__________________
Relationship to patient:___________________________________

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 that I may need during diagnosis and/or treatment.

____ Date: ______________________
Signature of patient, parent or guardian