John Fasbinder, DDS: Dental Surgery & Anesthesia

PATIENT INFORMATION FORM: (PLEASE PRINT)

TODAY'S DATE: ___________________

NAME: ____ NICKNAME: _________________ BIRTHDATE : _____________
FIRST MI LAST

ADDRESS: ____ CITY: _________________ STATE : _____ ZIP: _______

HOME PHONE: ___________________ WORK PHONE: ____________________ CELL PHONE: _______________________

EMAIL ADDRESS: ____ SOCIAL SECURITY #: __________________________

Preferred Contact Method (circle one): Home Phone Work Phone Cell Phone Email

HOW DID YOU HEAR ABOUT US?: ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME: _____________________________________ RELATION: ______________________ PHONE #: _________________

RESPONSIBLE PARTY/INSURANCE INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT: ____ RELATION: ______________
FIRST MI LAST

ADDRESS: ____ CITY: _________________ STATE : _____ ZIP: _______

HOME PHONE: ___________________ CELL PHONE: _______________________ BIRTHDATE : ________________

EMPLOYER: ____ WORK PHONE: ____________________

INSURANCE COMPANY: ____________________________________ GROUP #:________________UNION or LOCAL #: ____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ ***YES*** ☐ ***NO*** ***IF YES, PLEASE COMPLETE THE FOLLOWING:***

NAME OF INSURED: ____ RELATION: ______________
FIRST MI LAST

ADDRESS: ____ CITY: _________________ STATE : _____ ZIP: _______

HOME PHONE: ___________________ CELL PHONE: _______________________ BIRTHDATE : ________________

EMPLOYER: ____ WORK PHONE: ____________________

INSURANCE COMPANY: ____________________________________ GROUP #:________________UNION or LOCAL #: ____

I certify that I have read and understand the questions asked in this Patient Information section and the Patient Medical History section on the back side of this form. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Sign here: ____ **Date:** ________________
Patient, Parent, or Guardian

Is there a Guardian? **YES NO** *If YES, a copy of Guardianship Papers and DPOA (Durable Power of Attorney) are needed.*

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PATIENT MEDICAL HISTORY: (PLEASE PRINT)

PATIENT NAME: ____ BIRTHDATE : ____________

FIRST MI LAST

PRIMARY CARE PHYSICIAN/CLINIC NAME: ______________________________________ CLINIC PH #: _______________

		YES	NO
1.	Are you under medical treatment now?		
2.	Have you ever been hospitalized for any surgical operations or serious illness?		
3.	Are you currently on blood thinners?		
4.	Do you use tobacco? (chew/smoke)		
5.	Do you use alcohol, cocaine, or other drugs? *(If yes, circle type)*		

		YES	NO
6.	Are you wearing contacts?		
7.	WOMEN ONLY:		
	Are you pregnant or think you may be pregnant?		
	Are you nursing?		
	Are you taking birth control pills?		

Are you Allergic to or have you had any reactions to the following?

	YES	NO
Aspirin		
Barbiturates		
Codeine		
Iodine		

	YES	NO
Latex		
Local Anesthetics (ex., Novocaine)		
Penicillin or other Antibiotics		
Sulfa Drugs		

	YES	NO
Other (list below):		

Are you taking any medication(s) including non-prescription medicine/supplements? ☐ ***YES*** ☐ ***NO IF YES, PLEASE LIST BELOW:***

Name of Medicine/Supplement	Dosage/Frequency	Name of Medicine/Supplement	Dosage/Frequency

Do you have or have you had any of the following?

	YES	NO
AIDS or HIV		
Anemia		
Angina		
Arthritis		
Asthma		
Cancer		
Cardiac Pacemaker		
Chest Pains		
Diabetes		
Easily Winded		
Emphysema		
Epilepsy/Convulsions		
Fainting/Seizures		

	YES	NO
Frequently Tired		
Glaucoma		
Hay Fever/ Allergies		
Heart Attack		
Heart Disease		
Heart Murmur		
Heart Trouble		
Hepatitis/ Jaundice		
High Blood Pressure		
Joint Replacement or Implant		
Kidney Diseases		
Leukemia		
Liver Disease		

	YES	NO
Low Blood Pressure		
Radiation Therapy		
Respiratory Problems		
Rheumatic Fever		
Sexually Transmitted Disease		
Stomach Troubles/ Ulcers		
Stroke		
Swollen Ankles		
Thyroid Problem		
Tuberculosis		
Unexplained Weight Loss		
Other:		

OFFICE USE ONLY

PATIENT DENTAL HISTORY

		YES	NO
1.	Do your gums bleed while brushing or flossing?		
2.	Are your teeth sensitive to hot or cold liquids/foods?		
3.	Are your teeth sensitive to sweet or sour liquids/ foods?		
4.	Do you feel pain to any of your teeth?		
5.	Do you have any sores or lumps in or near your mouth?		
6.	Have you had any head, neck or jaw injuries?		
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking?		
	Pain (joint, ear, side of face?)		
	Difficulty in opening or closing?		
	Difficulty in chewing?		

		YES	NO
8.	Do you have frequent headaches?		
9.	Do you clench or grind your teeth?		
10.	Do you bite your lips or cheeks frequently?		
11.	Have you ever had any difficult extractions in the past?		
12.	Have you had any orthodontic work?		
13.	Have you ever had prolonged bleeding following extractions?		
14.	Have you ever had instruction on the correct method of brushing your teeth?		
15.	Have you ever had instructions on the care of your gums?		
16.	Do you experience dry mouth?		
17.	Would you like to change anything about your smile?		

What special needs do you have? ____