Schaffner Family Dental
Patient 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, parents names _____ Cell (_____)_____ Home (_____)_____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____ Work phone (_____)_____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you to our office? _____Soc. Sec #:_____

Preferred mehod of contact for appointment confirmation:

❑ Phone or ❑ Text (_____)_____ ❑ Email_____@_____.____

INSURANCE INFORMATION: ❑ Not covered by dental insurance or ❑ Dental Insurance Co._____

Group number_____ Member ID number: _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Member ID number:_____

Medical Health History

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

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

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Do you use street drugs? ❑ yes ❑ no

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

- ❑ Latex materials
- ❑ Penicillin or other antibiotics_____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics _____
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ Aspirin
- ❑ Asthma inhalers, cortisone or other steroids
- ❑ Nitroglycerin
- ❑ Osteoporosis (bone density) medicine
- ❑ List all over the counter and prescribed medications:

_____
_____
_____
_____
_____

Women Only:

- ❑ May be pregnant
  Expected delivery date:
- ❑ Nursing

Name of your physician:_____ Phone:_____

Do you have any disease, condition, or problem not listed above?_____

Signature of patient (or parent) _____ Date _____