RUSSELL B. FOX, DMD

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information is important to your dental health. *Please complete all attached forms.*

NAME _____Preferred name: _____

Date of Birth _____ SSN_____ Cell Phone: _____ Text Messages: Y / N

Mailing address_____

City_____State_____Zip_____

Email address: _____

EMPLOYER: _____OCCUPATION: _____

Person Responsible for payment if not you: _____Relationship to you_____

Dental Insurance_____ID#_____GROUP_____

Subscriber's Name_____Employer_____

Subscriber's date of birth _____ SSN_____

Name of your Primary Care Physician (PCP)_____

Name of pharmacy: _____City:_____

Dental disease is a combination of many factors; it is necessary to investigate any possible contributing factors

Please answer the following questions the best you can:

GENERAL HEALTH (please circle) Excellent Good Fair Poor

Have you taken any pain meds in the last week? Please circle: ASPIRIN MOTRIN TYLENOL OTHER

Current list of all medications you are taking: _____

**** ALLERGIC TO: LATEX ASPIRIN SULFA PENICILLIN / OTHER ANTIBIOTICS CODEINE NOVACAIN

Please list allergies to other medications: _____

Do you smoke? YES / NO *If yes, how many a day? _____ Prolonged Bleeding? YES / NO

Have you ever had or are in treatment of RADIATION / CHEMOTHERAPY? YES / NO

Have you had a joint replacement surgery? Yes / No *If yes please tell us when and what type of surgery you had. _____

Do you take any Pre-Medication antibiotic? Yes / No If yes what are you taking. _____

Please circle any of the listed conditions you may have

Acid Reflux	Depression	Multiple Sclerosis
Alcohol Sensitivity	Eating Disorder	Neurological Disorders
ALS	Epilepsy / Seizures	Organ Transplant recipient
Alzheimer's	Fainting / Dizzy	Osteoporosis
Anemia	Fibromyalgia	Pace Maker
Anxiety / Panic Attacks	Headaches / Migraines	Parkinson's Disease
Arthritis	Heart Attack	Rheumatic / Scarlet Fever
Asthma or Hay Fever	Heart Murmur	Rheumatoid Arthritis
Bell's Palsy	Hepatitis	Sinus Trouble
Cancer	High / Low Blood Pressure	Stroke
Cerebral Palsy	HIV / AIDS	Thyroid Issues
Chemical Dependency	Huntington's Disease	Tuberculosis / Lung Disease
Cold Sores	Jaundice / Liver Disease	Ulcers
Congenital Heart Disease	Leukemia	Vertigo
Diabetes 1 or 2	Lupus	
Dialysis / Kidney Disease	Mitral Valve Prolapse	

Do you have any health conditions not listed above?_____

*** Are you pregnant? YES / NO *** DUE DATE _____

*** Birth control, hormones or contraceptives? YES / NO *** If yes, what kind? _____

Do you have any oral health concerns? Dry mouth / staining / how your smile looks. Tell us more:

_____

** I certify that this health history is correct and I consent for the Patient named above to receive all necessary treatment. I understand that the proposed treatment will be explained to me by all the dental personnel and I have read and fully understand the H.I.P.P.A., Privacy Act.*

_____

***Patient, Parent or Guardian Signature** **Date**