Island Dental Center

Welcome! Please allow up to 5 minutes to complete this form

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☐ Dr ☐ Mr ☐ Mister ☐ Mrs ☐ Ms ☐ Miss

First Name* | Last Name* | Middle Initial | Birth Date*

Work Phone | Home Phone | Cell Phone | Email*

P.O. Box*

Sex*
☐ Male ☐ Female

Employer/School | Occupation

Employer/School Address

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Last Name* | First Name* | Phone Number*

Do you have DENTAL insurance?*
☐ Yes ☐ No

Name of Primary Insurance Company* | Primary Policy Holder*

Relationship* | Group #* | Policy #*

Do You Have Secondary/Other Insurance?*
☐ Yes ☐ No

Secondary Insurance Company* | Primary Policy Holder*

Relationship* | Group #* | Policy #*

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for answering the following questions.

Are you under a Physician's care right now?*
☐ Yes ☐ No

If 'yes' please explain*

Have you been hospitalized or had a major operation?*
☐ Yes ☐ No

If 'yes' please explain*

Have you ever had a serious head or neck injury?*
☐ Yes ☐ No

If 'yes' please explain*

Are you taking any medications, pills or drugs?*
☐ Yes ☐ No

If 'yes' please explain*

Do you use tobacco?*
☐ Yes ☐ No

Do you use controlled substances?*
☐ Yes ☐ No

Women Are You

Pregnant/Trying to get Pregnant?
☐ Yes ☐ No

Taking oral contraceptive?
☐ Yes ☐ No

Are you allergic to any type of the following?*

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other ☐ Not Applicable

If 'yes' please explain*

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

☐ AIDS/HIV Positive ☐ Anaphlyaxis ☐ Anemia ☐ Angina
☐ Artificial Heart Valve ☐ Artificial Joint ☐ Asthma ☐ Blood Disease
☐ Breathing Problem ☐ Bruise Easily ☐ Cancer ☐ Chemotherapy
☐ Cold Sores/Fever Blisters ☐ Congenital Heart Disorder ☐ Diabetes ☐ Drug Addiction
☐ Easily Winded ☐ Emphysema ☐ Epilepsy or Seizures ☐ Excessive Bleeding
☐ Faiting Spells/Dizziness ☐ Frequent Coughs ☐ Frequent Headaches ☐ Hay Fever
☐ Heart Attack/Failure ☐ Heart Murmur ☐ Heart Pacemaker ☐ Heart Trouble/Disease
☐ Hemophilia ☐ High Blood Pressure ☐ High Cholesterol ☐ Hives or Rash
☐ Hypoglycemia ☐ Kidney Problems ☐ Low Blood Pressure ☐ Mitral Valve Prolapse
☐ Osteoporosis ☐ Pain in Jaw Joints ☐ Radiation Treatment ☐ Recent Weight Loss
☐ Renal Dialysis ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Sickle Cell Disease
☐ Sinus Trouble ☐ Stomach/Intestinal Disease ☐ Stroke ☐ Thyroid Disease
☐ Tonsillitis ☐ Tuberculosis ☐ Tumors or Growth ☐ Ulcers

Have you had any serious illness not listed above?*
☐ Yes ☐ No

Comments*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to (or patient's) health. It's my responsibility to inform the dental office of any changes in medical status.

Sign up for Island Dental news
☐ Yes sign me up

Submit This Form

Whom may we thank for referring you?

Please type your initials in the box below.*