ZWEIGSCHWARTZMAN
PROSTHODONTICS

PATIENT INFORMATION

GENERAL INFORMATION (Please Print Clearly)

NAME _____ Dr.,Mr., Mrs., Miss, Ms.
Last Name First Middle

HOW WOULD YOU LIKE TO BE ADDRESSED BY OUR STAFF? _____

RESIDENCE _____
Number and Street City State Zip

RES. PHONE _____ **BUS. PHONE** _____ **CELL PHONE** _____

DATE OF BIRTH _____ **SOCIAL SEC #:** _____ **DRIVER'S LIC#** _____

E-MAIL ADDRESS _____

WHAT IS THE BEST WAY TO REACH YOU? _____

IF THAT DOESN'T WORK, WHAT IS THE NEXT BEST WAY? _____

OCCUPATION _____ **EMPLOYED BY** _____

BUS. ADDRESS _____
Number and Street City State Zip

DENTAL INSURANCE CARRIER _____ **ID #** _____ **Group#** _____

ARE YOU THE INSURED? | **YES** | **NO** | **IF NOT, WHO IS THE POLICY HOLDER?** _____

SPOUSE'S NAME _____ **OCCUPATION** _____ **EMPLOYED BY** _____

SPOUSE'S BUS. ADDRESS _____ **BUS. PHONE** _____

PERSON FINANCIALLY RESPONSIBLE _____ **RELATIONSHIP** _____

ADDRESS _____ **RES. PHONE** _____
Number and Street City State Zip

WHO CAN WE THANK FOR YOUR REFERRAL? _____

IN CASE OF EMERGENCY, CONTACT _____

ADDRESS _____ PHONE _____

PHARMACY NAME _____ PHONE _____

ADDRESS _____

ZWEIGSCHWARTZMAN
PROSTHODONTICS

HEALTH INFORMATION

Patient Name: _____ **Today's Date** _____

PHYSICIAN'S NAME _____

ADDRESS _____ PHONE _____

WHAT PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS DO YOU TAKE? _____

_____

ARE YOU ALLERGIC TO/OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Other: _____

Yes	No	Do you smoke or use tobacco?

HEIGHT _____ **WEIGHT** _____

WOMEN ONLY

Yes	No	Are you or could you be pregnant? If YES, what month? _____
Yes	No	Are you nursing?
Yes	No	Are you taking birth control pills?

DO YOU HAVE, HAVE YOU HAD OR HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? (Please Circle)

Abnormal Bleeding	Yes	No	Heart Attack	Yes	No
Alcohol Abuse	Yes	No	Heart Surgery	Yes	No
Anemia	Yes	No	Hepatitis A	Yes	No
Angina Pectoris	Yes	No	Hepatitis B	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Artificial Bones	Yes	No	Kidney Problems	Yes	No
Artificial Heart	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Mitral Valve	Yes	No
Cancer-Chemotherapy	Yes	No	Pace Maker	Yes	No
Congenital Heart	Yes	No	Pain in Jaw Joints	Yes	No
Cosmetic Surgery	Yes	No	Psychiatric Problems	Yes	No
Diabetes	Yes	No	Radiation Therapy	Yes	No
Drug Abuse	Yes	No	Rheumatic Fever	Yes	No
Emphysema	Yes	No	Seizures	Yes	No
Epilepsy	Yes	No	Sinus Problems	Yes	No
Fainting Spells	Yes	No	Stroke	Yes	No

Frequent Headaches	Yes	No	Taken Fen-Phen	Yes	No
Glaucoma	Yes	No	Thyroid Problems	Yes	No
HIV/AIDS	Yes	No	Tuberculosis	Yes	No
Hay Fever	Yes	No			

ALL PATIENTS

Yes	No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:_____ _____
Yes	No	Have you ever been pre-medicated for dental treatment, if YES, why _____
Yes	No	**Is there any issue or condition that you would like to discuss with the dentist in private?**
Yes	No	Are you in pain now? If YES, explain_____
Yes	No	Do you often find yourself clenching or grinding your teeth?

Patient Signature: _____ **Date:**_____

Guardian Signature: _____ **Date:** _____