TITANIUM DENTAL — PATIENT INFORMATION

Welcome to the office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's Name: _____ Birth Date: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Cell Number: _____ Receive Text Messages: Yes ☐ No ☐ Preferred Language: _____

MEDICAL HEALTH/HISTORY

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

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Diabetes - Type (1 / 2)
  - ❑ Most recent HbA1c level: _____
  - ❑ Date of most recent test: _____
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Sinus trouble
- ❑ Asthma

Do you smoke or use chewing tobacco? Yes____ No____

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

- ❑ Latex
- ❑ Antibiotics - If so, What kind? _____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
  - ❑ If so, what kind? _____
- ❑ Sulfa drugs
- ❑ Ibuprofen
- ❑ Other: _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other: _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

How did you hear about us? ☐ Google ☐ Facebook ☐ Instagram ☐ Groupon ☐ Other: _____

Name of Your General Dentist/ Clinic:_____

Do you have insurance? (Yes / No) If so, what kind? _____

- (Our office is out of network with all insurances, but we would love to help file your insurance claim form as an out-of-network office; some exceptions apply)

Please remember that there will be a $100 exam fee at the end of the consultation that will be credited towards your treatment.

Signature of patient (or parent): _____ Date: _____