Port City Family Dental Associates

Dr. Hilman Walden

Dr. David Beauchamp

PATIENT INFORMATION:

Name:_____ Preferred name:_____ Date:_____

DOB_____ Gender: Male____Female____ SS#_____

Address:_____ Zip:_____

Cell Phone #:_____Work #:_____Home #:_____

Place of employment:_____

How did you hear about us?_____

Emergency Contact:_____ Ph. #:_____

Relationship to patient:_____

Type of dental coverage: Insurance____Medicaid____Cash____

**If insurance, please give the insurance holders name:_____

SS#:_____DOB:_____ Place of employment:_____

Please present card to receptionist.

Last dental visit:_____ What dentist?_____

Medical Information:

Are you allergic to any medications? Y/N

If so, please list them all:_____
_____
_____

What pharmacy do you use?_____

Medical Doctor name and phone number:_____

Please circle if you have been treated for or have had any difficulty with any of the following conditions:

Heart Murmur Y/N	Rheumatic Fever Y/N	Epilepsy Y/N	Stroke Y/N
High Blood Pressure Y/N	Sinus Problems Y/N	Anemia Y/N	Ulcer Y/N
Excessive Bleeding Y/N	Allergies to Anesthetics Y/N	Kidney Problems Y/N	Mono Y/N
Diabetes Y/N	AIDS Y/N	Arthritis Y/N	
Hepatitis Y/N	Circulatory Problems Y/N	Psychiatric Care Y/N	
Hay Fever Y/N	Liver Disease Y/N	Tumors or Growths Y/N	
Injury to head or neck Y/N	Malignancies Y/N		

Have you had any replacements such as knee, hip, shoulder: Y/N

If yes, when was the procedure done and with what doctor?_____

Do you have any metal in any part of your body? Y/N

If yes, where?_____

Do you have to be premedicated before dental treatment (heart conditions, joint replacements, rheumatic fever, or metal in body) Y/N

Please list any surgeries:_____
_____

Please list any medications you are currently taking:_____
_____
_____

Are you pregnant? Y/N

If yes, how many weeks?_____

Please clarify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

SIGNATURE:_____ Date:_____