

Michael D. Gillespie, DDS

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's Name _____
Social Security # _____ Birthdate _____
Home Phone _____ Work phone _____ Cell Phone _____
Mailing address _____ City _____ State _____ Zip _____
Email Address _____
Employer _____

How did you hear about our office? _____

May we send appointment reminders by text messaging? _____ By email? _____

Responsible Party (if other than patient):

Name _____
Social Security # _____ Birthdate _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

BILLING, CREDIT, AND INSURANCE INFORMATION: Not covered by dental insurance

Employer _____
Dental Insurance Co. _____ (Please allow receptionist to copy your card)

MEDICAL HEALTH HISTORY

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

- Abnormal bleeding after extractions, surgery, or trauma
- AIDS or HIV positive
- Allergies or hives
- Anemia or blood disorders
- Arthritis
- Artificial joint or heart valve
- Do you need antibiotics before treatment? yes no
- Asthma
- Cancer or tumor
- Diabetes
- Epilepsy, seizures, or fainting spells
- Hayfever or sinus trouble
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Hepatitis or other liver disease
- High or low blood pressure
- Kidney disease
- Pacemaker
- Rheumatic fever or rheumatic heart disease
- Tuberculosis or other lung problems

Do you smoke or use chewing tobacco? yes no

Parents:

- May we take needed x-rays and give fluoride treatments to your child? yes no

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

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other medications _____

Women:

- Are you pregnant?
Expected delivery date: _____
- Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

I have read and agree to the Financial and Cancellation Policy, and have been given a copy of Privacy Rules.

Signature of patient, parent or guardian: _____ Date _____