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? _____

Is there anything you would like to change about your smile? _____

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

Have you been told you snore? ❑ yes ❑ no

Have you been told you stop breathing during sleep? ❑ yes ❑ no

Are you still tired after having slept 6-8hrs? ❑ yes ❑ no

Do you have frequent fatigue? ❑ 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

Parents:

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

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

_____

Signature of patient, parent or guardian: _____ Date_____