Middle Creek
FAMILY DENTISTRY

(919) 424-7203
MiddleCreekFamilyDentistry.com
7283 Hwy 42 West, Raleigh, NC 27503

Patient Information (Confidential)

Full Name:____ Date:_________________________

Male____ Female_____ SSN: ________________________________ Birthdate: ________________________________

Home Phone: _______________________________________ Cell Phone: ____

Address: ____ City: _______________________ Zip:__________ State:_______

E-Mail:____ I would like to receive correspondences via e-mail ___Yes ___No

Check Appropriate Box: _____ Minor______Single_____Married_____Divorced_____Widowed______Separated_______

If Student, Name of School/College:___________________________________ City:_________________________________

Patient's or Parent's Employer:_______________________________ Work Phone:_________________________

Business Address:___________________________________ City:______________________ State:____ Zip:__________

Spouse or Parent's Name (circle one):___________________ Employer:________________ Work Phone:_______________

How did you hear about our practice? ____

Emergency Contact: ______________________________ Relationship:__________________ Phone:_____________________

How can we contact you directly? ____ (cell, home, work, e-mail, etc.)

Responsible Party

Name of person responsible for this account:__________________________________ Relationship:_____________________

Address:____ Home Phone:_____________________________

Drivers License#:___________________________________ Birthdate:_____________________ SSN:_____________________

Employer:____ Work Phone:___________________________________

Is this person currently a patient in our practice? _____ Yes _____No

Insurance Information

Name of Insured: ___________________________Relationship:_____________ Birthdate: ___________ SSN: ______________

Name of Employer:__________________________ Address:_____________________________ Work Phone:_______________

Insurance Company:__________________________ ID#:_______________________________ Group#:___________________

Insurance Company Address:______________________ City:__________________ State:___________ Zip:_______________

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Middle Creek Family Dentistry Medical History

Name: Birthday:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now/Name/Number?	Yes	No	If yes, please explain___________________________
ve you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain___________________________
Have you ever had a serious head and neck injury?	Yes	No	If yes, please explain___________________________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain___________________________
› you take, or have you ever taken, Phen-Fen or Redux?	Yes	No	If yes, please explain:___________________________
Are you on a special diet?	Yes	No	If yes, please explain:___________________________
Do you use tobacco?	Yes	No	If yes, please explain:___________________________
Do you use controlled substances?			
ve you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes, please explain:___________________________

Women:

Any possibility of being pregnant? Y N Trying to get pregnant? Y N Nursing? Y N Taking Oral Contraceptives? Y N

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other, Please List____________________

Do you have, or have you had any of the following?

AIDS/HIV Positive	Y N	Diabetes	Y N	Herpes	Y N	Rheumatism	Y N
Alzheimer's Disease	Y N	Drug Addiction	Y N	High Blood Pressure	Y N	Scarlett Fever	Y N
Anaphylaxis	Y N	Easily Winded	Y N	High Cholesterol	Y N	Shingles	Y N
Anemia	Y N	Emphysema	Y N	Hives or Rash	Y N	Sickle Cell Disease	Y N
Angina	Y N	Epilepsy or Seizures	Y N	Hypoglycemia	Y N	Sinus Trouble	Y N
Arthritis/Gout	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Artificial Heart Valve	Y N	Excessive Thirst	Y N	Kidney Problems	Y N	Stomach/Intestinal Disease	Y N
Artificial Joint	Y N	Fainting Spells/Dizziness	Y N	Leukemia	Y N	Stroke	Y N
Asthma	Y N	Frequent Cough	Y N	Liver Disease	Y N	Swelling of Limbs	Y N
Blood Disease	Y N	Frequent Diarrhea	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Blood Transfusion	Y N	Genital Herpes	Y N	Lung Disease	Y N	Tonsillitis	Y N
Breathing Problems	Y N	Glaucoma	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Bruise Easily	Y N	Hay Fever	Y N	Osteoporosis	Y N	Tumors or Growths	Y N
Cancer	Y N	Heart Attack/Failure	Y N	Pain in Jaw Joints	Y N	Ulcers	Y N
Chemotherapy	Y N	Heart Murmur	Y N	Parathyroid Disease	Y N	Venereal Disease	Y N
Chest Pains	Y N	Heart Pacemaker	Y N	Psychiatric Care	Y N	Yellow Jaundice	Y N
Cold Sores/Fever Blisters	Y N	Heart Trouble/Disease	Y N	Radiation Treatment	Y N		
Congenital Heart Disease	Y N	Hemophilia	Y N	Recent Weight Loss	Y N		
Convulsions	Y N	Hepatitis A	Y N	Renal Dialysis	Y N		
Cortisone Medicine	Y N	Hepatitis B or C	Y N	Rheumatic Fever	Y N		

Have you ever had any serious illness not list above? Y N If yes, please explain:____

Do you have sleep apnea?	Yes	No	if yes, do you wear a CPAP machine?	Yes	No
Do you drink grapefruit juice?	Yes	No	Do you use Aspirin, Antacids or Sudafed?	Yes	No
Do you take St. Johns Wart?	Yes	No	Have you had gastric bypass surgery?	Yes	No

Do you use herbal supplements? If so, please list:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: ____

DATE: __________________________________