Elrod, Green and Heimer DDS
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frontdesk@eghdds.com

Are there any changes with your dental insurance?

◯ Yes ◯ No

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

School if student and status (ie. FT, PT)

_____

2 Emergency Contacts (names and phone numbers):

_____

How did you hear about our office?

☐ Phone Book ☐ Newspaper
☐ Radio Ad ☐ Internet
☐ Other ☐ Friend or Family (name below)

Name of person or other source referring you to our practice:

_____

Have you ever been told you need to take an antibiotic prior to dental treatment?

◯ Yes ◯ No

Any changes in your health within the last year?

◯ Yes ◯ No

Please check to indicate if you have had any of the following diseases or problems.

Cardiovascular (Heart)

- ☐ High blood pressure
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Irregular heart beat
- ☐ Heart surgery
- ☐ Heart failure
- ☐ Blood thinners
- ☐ Damaged Heart Valve
- ☐ High cholesterol
- ☐ Heart Infection
- ☐ Stroke
- ☐ Artificial Heart Valve

Hematologic (Blood)

- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Abnormal bleeding

Respiratory (Breathing)

- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Sleep Apnea
- ☐ Difficulty Breathing
- ☐ Tuberculosis/TB

Endocrine

- ☐ Diabetes
- ☐ Thyroid problem

Renal (Kidney)

- ☐ Kidney disorder
- ☐ Dialysis

Immune

- ☐ Past use of steroids
- ☐ Delayed healing

Musculoskeletal (Muscles/Bones/Joints)

- [ ] Arthritis
- [ ] Artificial joint
- [ ] Fibromyalgia
- [ ] Lupus
- [ ] Sjogren's Syndrome
- [ ] Osteoporosis
- [ ] Bone Density Meds

Gastrointestinal

- [ ] Acid reflux/GERD
- [ ] Irritable bowel sydrome
- [ ] Stomach ulcer

Hepatic (Liver)

- [ ] Liver disease
- [ ] Jaundice
- [ ] Hepatitis

Neurologic

- [ ] Epilepsy/seizures
- [ ] Parkinson's Disease
- [ ] Multiple sclerosis
- [ ] Headaches

Eyes/Ears

- [ ] Glaucoma
- [ ] Impaired vision
- [ ] Impaired hearing

Mental Heatlth

- [ ] Bipolar disorder
- [ ] Depression
- [ ] Anxiety
- [ ] Eating disorder
- [ ] Sleep disorder
- [ ] Dementia
- [ ] Learning disorder

Infections

- [ ] HIV positive/AIDS
- [ ] Sexually transmitted disease

Allergies

- [ ] Local Anesthetic
- [ ] Antibiotics
- [ ] Aspirin
- [ ] Ibuprofen
- [ ] Acetaminophen
- [ ] Codeine/narcotics
- [ ] Metals
- [ ] Sulfa
- [ ] Latex
- [ ] Other

Other

- [ ] Cancer
- [ ] Cancer treatment
- [ ] Pregnant
- [ ] Nursing infant
- [ ] Tobacco use
- [ ] Alcohol use
- [ ] Chemical dependency
- [ ] Recreational drug use
- [ ] Have you traveled abroad in the last year

Please list any disease, condition, or problem you have that is not listed above.

Please list any hospitalizations or surgeries you have had.

Please list any medications you are currently taking (or provide us with a list to copy).

Name of Physician and clinic phone number:

Additional Information

To the best of my knowledge, the preceding information is complete and accurate.

Signature: _____ Date:

Response Date: