Virenchandra R. Patel, D.D.S.

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Patient Information

Please Print

Date _____
Patients Name_____ Preferred Name_____
Home Address _____ Home Phone _____
City _____ State _____ Zip_____ Work Phone _____
Age _____ Birth Date _____ Social Security # _____Male/Female____ Cell Phone _____
If patient is a minor, give parent=s or guardian=s name _____
How did you hear about our office ? _____
Has any member of your family been at this office before ? Names : _____

Medical History

Does the patient have or has he/she ever had any of the following conditions :

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Hepatitis/Liver Disease
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Disease	☐	☐	Epilepsy
☐	☐	Lung Disease	☐	☐	Scarlet Fever
☐	☐	Thyroid Disease	☐	☐	Nervous Disorder
☐	☐	High Blood Pressure	☐	☐	AIDS / HIV +
☐	☐	Metallic Implant	☐	☐	Tuberculosis
☐	☐	Glaucoma	☐	☐	Cold Sores/Fever Blister
☐	☐	Blood Transfusion	☐	☐	Bleeding Gums
☐	☐	Women: Are you Pregnant Now?	☐	☐	Injury to Front Teeth
☐	☐	Tumor/Cancer	☐	☐	Bad Breath
☐	☐	Prolonged Bleeding When Cut	☐	☐	Stained tooth
☐	☐	Latex or metal Allergy	☐	☐	Have you ever taken Fosamax Zometa, Aredia, (bisphosphonates)
☐	☐	Have you ever taken any prescription drugs fenflutamine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux)			
☐	☐	Food/Drug Allergy. If yes, please list_____			

Is the patient taking any medications ? If yes, please list the medications _____
_____
Does the patient routinely take health related substances? (Vitamins, herbal supplements, natural products} If yes, please list _____
_____
Has the patient recently been under the care of a physician. If yes, for what reason _____
_____
Name of medical doctor for above reason _____
Has the patient been hospitalized in the past five years ? (If yes, please explain) _____
_____
Has the patient had a serious illness or operation ? (If yes, please explain) _____
_____

I will immediately inform the doctor if there are any changes in the medical history.

Patient Signature. _____ Date_____

Medical History Reviewed by

Signature _____ Date_____

Dental History

Last Dental Care : Date _____Dentists Name_____ Address_____
Nature of Dental Care Provided _____

Responsible Party Information

Name _____
Address _____
How long at this address _____ Home Phone _____
Previous address (if less than 3 years) _____
Social Security # _____ Birth Date _____ Relationship to patient _____
Employer _____ Occupation _____ Yrs Employed _____
Employer's Address _____ Work Phone _____
Spouse's Name _____Birth date _____Soc. Sec. # _____
Spouse's Address (if different) _____ Home Phone _____Occupation _____
Spouse's Employer _____ Work Phone _____ Yrs employed _____
Employer=s Address _____

Dental Insurance Information

Insured's Name_____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No _____ Local No. _____
Insurance Co. Address _____

Do you have dual Coverage ? ☐ Yes ☐ No If yes :
Insured's Name_____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No _____ Local No. _____
Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

I give my consent for Dr. Patel to do a complete/emergency oral and dental examination on the patient named previously. X-rays that are necessary to properly complete the exam may be taken. If a cleaning, fluoride treatment, and oral hygiene instruction are to be included in the first examination, I will be informed. Any additional dental treatment received will be fully explained prior to starting treatment.

I understand that I am fully responsible for the cost of any treatment carried out regardless of insurance.

Additional Comments : _____
_____
_____
_____

I have also received a copy of the Dental Materials Fact Sheet.

Signed _____Date_____