M. Kenneth Johnson, D.M.D.

Patient Information and Medical History

Patient Information (Confidential)

SS#/SIN_____

Name_____ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Email _____ Work Phone_____ Cell Phone _____

○ Minor ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

If Student, Name of School/College_____ City_____ State _____

Patient or Parent/Guardian's Employer_____ Phone_____

Spouse or Parent/Guardian's Name_____ Employer_____

Whom May We Thank for Referring You? _____

Person to Contact In Case of Emergency _____ Phone_____

Responsible Party

Relationship

Name of Person Responsible for this Account _____ to

Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone _____

Employer _____ SS#/SIN_____ Work Phone _____

Is This Person Currently a Patient in our Office? ○ Yes ○ No

Insurance Information (Primary)

Relationship

Name of Insured _____to Patient_____

Birthdate_____ SS#/SIN_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____ ID#_____
Ins. Co Address_____ City_____State_____Zip_____

Do You Have ANY Additional Dental Insurance? If so, please complete the following section.

Insurance Information (Secondary)

Relationship

Name of Insured _____to Patient_____

Birthdate_____ SS#/SIN_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Group#_____ ID#_____

Ins. Co Address_____ City_____State_____Zip_____

Patient Medical History

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

Date of

Physician_____Office Phone_____Last Visit_____

1. Are you a physician's care now? ○ Yes ○ No
2. Have you ever been hospitalized or had a major operation? ○ Yes ○ No
3. Have you ever had a serious head or neck injury? ○ Yes ○ No
4. Are you taking any medications, pill, or drugs? ○ Yes ○ No
5. Do you or have you taken Bisphosphonates? ○ Yes ○ No
6. Are you on a special diet? ○ Yes ○ No
7. Do you use tobacco? ○ Yes ○ No

8. Do you use controlled substances? ○ Yes ○ No

Women Only: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No

Taking Oral Contraceptives? ○ Yes ○ No

Nursing? ○ Yes ○ No

Are you allergic to any of the following?

○Aspirin ○Penicillin ○Codeine ○Acrylic ○ Metal ○Latex ○Local Anesthetics

○Other If Yes, please explain your reaction_____

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

AIDS/HIV Positive	○Yes ○ No	Hepatitis A	○Yes ○ No
Anemia	○Yes ○ No	Hepatitis B or C	○Yes ○ No
Angina	○Yes ○ No	High Blood Pressure	○Yes ○ No
Arthritis/Gout	○Yes ○ No	Kidney Problems	○Yes ○ No
Artificial Heart Valve	○Yes ○ No	Leukemia	○Yes ○ No
Artificial Joint	○Yes ○ No	Liver Disease	○Yes ○ No
Asthma	○Yes ○ No	Low Blood Pressure	○Yes ○ No
Breathing Problem	○Yes ○ No	Mitral Valve Prolapse	○Yes ○ No
Cancer	○Yes ○ No	Radiation Treatments	○Yes ○ No
Chest Pains	○Yes ○ No	Recent Weight Loss	○Yes ○ No
Congenital Heart Disorder	○Yes ○ No	Rheumatic Fever	○Yes ○ No
Diabetes	○Yes ○ No	Stomach Problems/Ulcers	○Yes ○ No
Easily Winded	○Yes ○ No	Stroke	○Yes ○ No
Emphysema	○Yes ○ No	Swelling of Limbs	○Yes ○ No
Epilepsy/Seizures	○Yes ○ No	Thyroid Disease	○Yes ○ No
Fainting Spells/Dizziness	○Yes ○ No	STD	○Yes ○ No
Glaucoma	○Yes ○ No	Other: _____	○Yes ○ No

Hay Fever/ Allergies ○Yes ○ No

Heart Attack/Failure ○Yes ○ No

Heart Murmur ○Yes ○ No

Heart Pace Maker ○Yes ○ No

Heart Trouble/ Disease ○Yes ○ No

Comments: _____

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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 my patient's) health. It is my responsibility to inform Dr. Johnson's office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN **DATE**