Baker Sisters Family Dental Care

Come find your happy, healthy, dental home!

8025 Ritchie Hwy, Suite 205, Pasadena MD ph (410) 768-7740
www.bakersistersfamilydentalcare.com

Patient Information

Date:_____

Patient Name: _____ Nickname: _____ Age:_____
last first

Gender: M___ F___ Birthdate: ____/_____/_____ Social Security Number:_____

Mailing Address: _____

Home Phone: (_____)_____-_____ Cell: : (_____)_____-_____ Preferred Contact: _____

Email Address:_____ How did you hear about our practice?_____

Emergency Contact:_____ Phone Number: _____

Employee:_____ Work Phone: (____)_____-_____

Responsible Party

Name of person responsible for this account (if other than yourself)_____

Relationship_____ DL#_____ SS#_____ Birthdate___/___/___

Mailing Address:_____

Home Phone: (_____)_____-_____ Cell: (____)_____-_____ Work Phone: (_____)_____-_____

Employer:_____ Email Address: _____

Is this person currently a patient in our office? **Y / N**

Insurance Information

Primary

Name of Insured:_____

Relationship:_____SS#_____

Birthdate: ___/___/____ Work Phone: (___)____-_____

Employer: _____

Employer Address: _____

Insurance Company:_____ Group #:_____

Secondary

Name of Insured:_____

Relationship:_____SS#_____

Birthdate: ___/___/____ Work Phone: (___)____-_____

Employer: _____

Employer Address: _____

Insurance Company:_____ Group #:_____

Medical History

Physician's name:_____ Phone Number: (____)_____-_____

Are you currently under a physician's care? Y/ N If yes, please explain:_____

Have you had any hospitalzations, operations, or major surgeries? Y/ N If yes, please explain: ____

_____

Do you have any of the following?

☐ AIDS/HIV	☐ Anemia	☐ Arthritis, Rheumatism
☐ Artificial Heart Valves	☐ Artificial Joints	☐ Asthma
☐ Asthma	☐ Back Problems	☐ Abnormal Bleeding
☐ Cancer	☐ Chemotherapy	☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disease	☐ Cortisone Treatments	☐ Diabetes
☐ Emphysema	☐ Epilepsy or Seizures	☐ Fainting or Dizziness
☐ Glaucoma	☐ Heart Attack, Surgery, Disease	☐ Heart Murmur
☐ Heart Pacemaker	☐ Hepatitis Type____	☐ Headaches
☐ Herpes	☐ High Blood Pressure	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Parathyroid Disease
☐ Psychiatric Care	☐ Radiation Treatment	☐ Respiratory Disease
☐ Renal Dialysis	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Shingles	☐ Sickle Cell Disease	☐ Sinus Trouble
☐ Stroke	☐ Stomach Disease	☐ Intestinal Disease
☐ Swollen Neck /Glands	☐ Thyroid Disease	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors / Growths	☐ Venereal Disease

Do you have any conditions not mentioned? Y/ N If yes, please explain:_____

_____

Women: Are you pregnant? **Y/N** If yes, due date __/__/__

Are you taking oral contraceptives? **Y/ N**

Medications: List any medications you are taking and correlating diagnosis.

_____

_____

_____

Are you currently taking, or have you ever taken Bisphosphonates? Y/ N

Allergies: Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Sulfa

☐ Other:_____

Habits:

☐ Do you use tobacco? Type:_____ How long? _____ How much per day?_____

☐ Do you use alcohol? How much per week? _____

☐ Do you use drugs?

Dental History

Reason for today's visit?_____ Former dentist_____ Date of last dental visit__/__/__

How often do you brush?_____ How often do you floss? _____

Any sensitivity in your mouth? **Y/N** If yes, please explain. _____

Are you happy with your smile? If no explain_____

Are you on well water?_____