Loftin
Dental Center

Annual Patient Information Updated (2024)

*****ALL PATIENTS MUST UPDATE THEIR INFORMATION YEARLY******

Date: _____

PERSONAL INFORMATION

THIS IS CURRENT INFORMATION ON FILE:

Address: _____

City: _____ State: _____

Zip: _____

Phone: _____ Work: _____

Email: _____

Birthday: _____/_____/_____ SSN: _____

Employer: _____

Marital Status: Single/ Married/ Divorced/ Widowed/ Separated

Driver's License /ID #: _____ State: _____

PARENT/GUARDIAN INFORMATION *(must complete if under the age of 18)*

Name: _____ *Birthday:* _____/_____/_____ *Sex:* ____M ____F

Address: _____ *Driver's License /ID #:* _____ *State:* _____

City/State: _____ *Zip:* _____ *Social Security #:* _____

Relationship: Mother/Father/Grandparent/Other: _____ *Phone Number:* _____

Emergency Contact: _____

Relationship: Mother/Father/Grandparent/Other: _____ *Phone Number:* _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____ Policy Holder SSN #: _____

Group/Company Name: _____ Policy Holder Date of Birth: _____

Insurance Member ID #: _____ Address (if Different): _____

PRIMARY PHYSICIAN/ SPECIALIST

Physician Name: _____ Specialist: _____

Phone: _____ Phone: _____

Pharmacy: _____

All medical history must be listed here to accommodate your visit correctly.

MEDICAL HISTORY

Have you been tested for sleep apnea? □ Yes □ No

Have you been diagnosed /treated for TMJ or TMJD? □ Yes □ No

Do you require a premedication prior to treatment? □ Yes □ No **(PREMED)**

Are you allergic to Penicillin, Aspirin, or any other drug? □ Yes □ No Other: _____

Have you ever had a reaction to Novocain or Anesthesia? □ Yes □ No Date: _____

HAVE YOU EXPEREINCED ANY OF THESE CONDITIONS IN THE LAST 4-6 WEEKS?

Active pink eye? □ Yes □ No

History of Head Lice? □ Yes □ No Currently have Head Lice? □ Yes □ No Last Date of Treatment: _____

Are vaccinations up to date? □ Yes □ No

For women only: Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Had exposure to HPV? □ Yes □ No

HAVE YOU EVER USED A BISPHOSPHONATE MEDICATION? FOSAMAX, ACTONEL, ATELVIA, DIDRONEL, BONIVA. **□ YES □ NO**

*****Please continue on the backside of this sheet*****

Past or Present History of (Circle all that apply): □ **None Apply**

Accidental Injury to teeth/mouth
Burning of Tongue
Clench/Grind Teeth
Dry Mouth
Gums Swollen, Tender, Bleeding
Lip or Cheek Biting
Mouth Breathing
Sensitivity to Hot/Cold
Blisters on Lips, Tongue, Mouth, Cold Sores
Chew on One Side of Mouth
Dental Fractures
Growths or Lesions in Mouth
Head, Neck, Jaw Pain
Loose Teeth or Broken Fillings
Orthodontic Treatment
Periodontal Treatment

When was your last dental visit? _____ How often do you floss? _____

How often do you brush your teeth? _____ Are you in pain? _____

Is the damaged tooth a capped or previously restored tooth? _____

Have you had any of the following? (Circle all that Apply) or Check □ **None Apply**

AIDS/HIV
ADD, ADHD
Anemia
Arthritis, Rheumatism, Cortisone Treatments
Asthma, Shortness of Breath, Respiratory Disease
Anxiety, Depression
Artificial Joints, Surgical Implant
Back Problems, Spine Bifida
Cancer/ Chemotherapy/ Radiation Treatment
Circulatory Problems, Blood Transfusion
Cholesterol □ High □ Low
Cough, Coughing Blood
Fainting
Glaucoma/Cataracts
Hemophilia/ Abnormal Bleeding
Psychiatric Care/Bipolar
Shingles, Skin Rash, Scarlet Fever
Hepatitis (A B C)
Kidney Disease. Malfunction
Material Allergies: Latex, Wool, Metal, Chemicals
Ulcer/Colitis
Anaphylaxis
Autism
Diabetes, Swelling of Feet/Ankles
Artificial Heart Valves/Joints/ Mitral Valve Prolapse
Atopic (Allergy Prone)
Heart Surgery, Pacemaker
Heart Attack/Stroke
Blood Disease
Chemical Dependency, Tobacco Habit
Cortisone Treatments
Epilepsy/Seizures
Food Allergies
Headaches/Migraines
Heart Murmur/Problems
Herpes
High Blood Pressure
Muscular Disease: _____
Liver Disease/ Cirrhosis
Thyroid Disease, Malfunction, Tonsillitis
Tuberculosis
Venereal Disease

Are there any other health conditions you may have that are not listed? _____

MEDICATIONS

Does the patient have any drug allergies? If Yes, list all. □ **No Know Allergies**

_____

_____

Please list **ALL** medications you are currently taking: □ **None at this time**

_____

_____

ACKNOWLEDGE AND AGREE TO 2024 OFFICE/INSURANCE POLICIES? _____ **INITIALS**

ACKNOWLEDGE AND SIGNED 2024 HIPPA POLICY? _____ **INITIALS**