TITANIUM DENTAL — PATIENT INFORMATION

Welcome to the office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's Name: _____ Birth Date: _____

Email Address: _____

Cell Number: _____ Preferred Language: _____

MEDICAL HEALTH/HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❏ Cancer or tumor
- ❏ Heart ailment or angina
- ❏ Heart murmur, mitral valve prolapse, heart defect
- ❏ Artificial joint or valve
- ❏ High or low blood pressure
- ❏ Pacemaker
- ❏ Tuberculosis or other lung problems
- ❏ Kidney disease
- ❏ Hepatitis or other liver disease
- ❏ Alcoholism
- ❏ Diabetes - Type (1 / 2)
  - ❏ Most recent HbA1c level: _____
  - ❏ Date of most recent test: _____
- ❏ Neurologic condition
- ❏ Epilepsy, seizures, or fainting spells
- ❏ Herpes or cold sores
- ❏ AIDS or HIV positive
- ❏ Anemia or blood disorders
- ❏ Abnormal bleeding after extractions, surgery, or trauma
- ❏ Sinus trouble
- ❏ Asthma

Do you smoke or use chewing tobacco? Yes____ No____

Are you allergic to, or have you reacted adversely to any of the following?

- ❏ Latex
- ❏ Antibiotics - If so, What kind? _____
- ❏ Local anesthetics ("Novocain")
- ❏ Codeine or other narcotics
  - ❏ If so, what kind? _____
- ❏ Sulfa drugs
- ❏ Ibuprofen
- ❏ Other: _____

Are you taking any of the following?

- ❏ Aspirin
- ❏ Anticoagulants (blood thinners)
- ❏ Antibiotics
- ❏ Antidepressants or tranquilizers
- ❏ Insulin, Orinase, or other diabetes drug
- ❏ Nitroglycerin
- ❏ Cortisone or other steroids
- ❏ Osteoporosis (bone density) medicine
- ❏ Other: _____

Women:

- ❏ May be pregnant
  Expected delivery date: _____
- ❏ Taking hormones or contraceptives

How did you hear about us? ☐ Google ☐ Facebook ☐ Youtube ☐ Instagram ☐ Groupon ☐ Other: _____

Name of Your General Dentist/ Clinic:_____

Do you have insurance? (Yes / No) If so, what kind? _____

- (Our office is out of network with all insurances, but we would love to help file your insurance claim form as an out-of-network office; some exceptions apply)

Please remember that there will be a $100 exam fee at the end of the consultation that will be credited towards your treatment.

Signature of patient (or parent): _____ Date: _____