Pure Dental Care
122 Courtyard Drive
Hillsborough, NJ 08844

PATIENT INFORMATION

Patient's name _____ Preferred name _____ Date of Birth_____

If minor, parents names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____State _____ Zip _____

Social Security_____ Email_____

INSURANCE INFORMATION:

POLICY HOLDERS NAME:_____ **DATE OF BIRTH (POLICY HOLDER)**_____

Dental Insurance Name_____ **SS#**_____

Insurance ID Number_____**Insurance Phone#**_____

How did you find our office?_____

Pharmacy Name and Phone Number:_____

What Brand toothpaste do you use:_____

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
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition, depression
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Autoimmune disease
- ❑ Other_____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

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

- ❑ Latex materials
- ❑ Penicillin
- ❑ Clindamycin
- ❑ Other antibiotics_____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other Allergies:_____

Are you taking any of the following medications?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medication
- ❑ **Other medications**:_____
- ❑ _____
- ❑ _____

Women:

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

Signature of Patient (or Parent) ____Date ___________________