CONFIDENTIAL PATIENT INFORMATION
Sean Tahaney, D.D.S.

Today's date ______/______/______
Name____________________________Address________________________________
City____________________State_____Zip_____________ Home phone____________
Physician____ Work phone____________
Employment______________________________________ Cell phone____________
Birth date ____/____/_____ Marital status___________

Welcome to our office! Please circle the correct answer:

Are you being treated for any condition by a physician? ....Yes No
Are you taking any medications? .... Yes No
Please list medications:

____

____

Has there been any change in your health in the last year? ....Yes No
Have you ever been seriously ill? ....Yes No
Have you ever had any major operations? .... Yes No

Please circle any of the following conditions you have or have had:

Seizures
Fainting
Nervousness
Stroke
Glaucoma
Cold sores
Emphysema
Tuberculosis
Asthma
Hay fever
Sinus problems
Anemia
Blood disease
Bleed easily

Hemophilia
Heart problems
Angina
High blood pressure
Rheumatic fever
Heart murmur
Mitral valve prolapse
Congenital heart problems
Heart surgery
Prosthetic heart valve(s)
Pacemaker
Blood transfusion(s)
Liver disease
Hepatitis: type_______

Ulcers
Kidney problems
Venereal disease
Diabetes
Thyroid problems
AIDS/HIV positive
Arthritis
Painful jaw joints
Prosthetic joints
Hives
Steroid medication
Drug addiction
Alcoholism
Cancer/radiation

Do you have any disease, condition, or problem not listed above? If so, what? _________
____

Please circle if you have had an unusual reaction to any of the following:

Penicillin
Other antibiotics
Dental anesthetic
Sulfites

Sulfa
Iodine
Codeine
Other medications

Narcotics
Aspirin
Latex

Do you ever have chest pain? .... Yes No
Do you ever have trouble with infections? .... Yes No
Do you smoke now, or do you have a history of smoking? .... Yes No
Females Only --- Are you, or might you be pregnant? .... Yes No
Are you taking birth control pills? .... Yes No
Have you ever had a reaction to any metals? .... Yes No
Have you ever had excessive bleeding from an extraction or other wound? Yes No
Have you ever had an injury to your face or jaws? .... Yes No
Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition in your mouth? .... Yes No
Do you have sensitive teeth? .... Yes No
Have you had a toothache recently? .... Yes No
Do you have bleeding gums? .... Yes No
Circle the fluorides you have had: in water by tablet topical (placed on teeth) in toothpaste
Approximately how long has it been since your last dental visit? ____________________
Who may we thank for your referral to our office? ________________________________

PERSON RESPONSIBLE FOR ACCOUNT:

Name __________________________ Relationship ___________ S.S. # _____________
Address ________________________ City_____________ State _______ Zip _________
Telephone Home: __________________________ Business/Cell: ___________________

PRIMARY DENTAL INSURANCE INFORMATION:

Employee name ______________________________ Employee date of birth __________
Employer ___________________________________ Insurance Co. _________________
Address _________________________ City ____________ State _________ Zip ______
Telephone __________________ Program or policy # ____________________________
Group ____ S.S. # __________________

SECONDARY DENTAL INSURANCE INFORMATION:

Employee name ______________________________ Employee date of birth __________
Employer ___________________________________ Insurance Co. _________________
Address _________________________ City ____________ State _________ Zip ______
Telephone __________________ Program or policy # ____________________________
Group ____ S.S. # __________________

Patient's or Guardian's Signature ____
Date _________________________