NEW PATIENT INFORMATION

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

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____

Home phone _____ Work phone _____ Mobile phone _____

Email _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

EMERGENCY CONTACT Name _____ Home/mobile phone_____

HOW DID YOU HEAR ABOUT US? ❑ Friend/Family Please tell us who so we can thank them:_____

❑ Yelp ❑ Google ❑ Facebook ❑ YouTube ❑ Other - Please explain_____

PREFERRED PHARMACY (Name/Address):_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____

Group #_____ Member #_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's Social Security number: _____ Spouse's Date of Birth_____

Dental Insurance Co._____ Group #_____ Member #_____

MEDICAL HEALTH HISTORY

Are you under a physician's care right now? ❑ yes ❑ no If yes, please explain_____

Have you ever been hospitalized or have had a major operation? ❑ yes ❑ no If yes, please explain_____

Have you ever had a serious head or neck injury? ❑ yes ❑ no If yes, please explain_____

Are you taking any medications, pills, or drugs? ❑ yes ❑ no If yes, please explain_____

Do you taken, or have you taken, Phen-Phen or Redux? ❑ yes ❑ no If yes, please explain_____

Are you on a special diet? ❑ yes ❑ no If yes, please explain_____

Do you smoke or use tobacco? ❑ yes ❑ no

Patient's name _____ Date of Birth _____

Do you use controlled substances? ❑ yes ❑ no

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
- ❑ 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

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

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

Are you taking any of the following?

- ❑ 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) medicine
- ❑ Other:_____
  _____

Women:

- ❑ **Pregnant/Trying to get pregnant?**
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Your Primary Physician Name:_____ Phone:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information to my (or patient's) health. It is my responsibility to inform Pasadena Pain Management about any changes to my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE_____