MOUNTAIN RIDGE
DENTISTRY

Patient Health Information

General Information	
First Name:	
Last Name:	
Date of Birth:	
Social Security Number:	
Marital Status:	
Spouse's Name:	
Family Physician Name:	

Contact Information	
Cell/Home Phone:	
Work Phone:	
Address:	
City:	
State:	
Zip:	

Employment Information	
Employer:	
Work Phone:	

Insurance Information	
Insurance Company:	
Insurance Phone #: *(Listed on card)*	
Subscriber Name:	
Subscriber SSN:	
Subscriber Birthday:	
Subscriber Number:	

Medical History	
	Cancer or tumor
	Heart ailment or angina
	Heart murmur, mitral valve, 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 / frequent headaches
	Anemia or blood disorders
	Abnormal bleeding after extractions, surgery, or trauma
	Hayfever or sinus trouble
	Allergies or hives
	Asthma
	Other Conditions:

_____

Patient/Parent Signature

_____

Date

310 Mountain Avenue, Berthoud CO 80513 ∞ 970.528.0900 ∞ **mountainridgedentistry.com**

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Patient Health Information

Page Two

Current Health
Do you smoke or chew tobacco? Y N
Do you use alcohol? If so, how frequently?
List ALL Allergies:
List ALL Current Medications and Prescriptions:
Pregnant?

Dental Health
Do you clench or grind your teeth? Y N *Optional explanation:*
Do your gums bleed at any time? Y N *Optional explanation:*
How you do feel about visiting the dentist?
Anything else not listed on this sheet?

_____

Patient Printed Name

_____ _____

Patient/Parent Signature **Date**

We protect and encrypt your information to ensure confidentiality.

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