Fan Family Dental
689 W. Renner Rd Suite 111
Richardson, TX 75080
Ph # : 972-234-5700

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Student		SSN	
Email				School Name			
				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? No		Do you have Secondary Dental Insurance? __ Yes __ No	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Phone #		Phone #	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To

- Y N No Known Allergies
- Y N Aspirin
- Y N Barbiturates / Sleeping Pills
- Y N Codeine
- Y N Erythromycin
- Y N Iodine
- Y N Latex Rubber
- Y N Local Anesthetics
- Y N Metals
- Y N No Epinephrine
- Y N Penicillin
- Y N Prior Hepatitis
- Y N Sulfa Drugs
- Y N Other Narcotics

Check, if applicable

- Y N No Change Since Last Recorded
- Y N No Known Concerns or Issues

- Y N Alcohol/Drug Abuse
- Y N Anemia / Leukemia
- Y N Ankles Swell
- Y N Anorexia / Bulimia
- Y N Arthritis
- Y N Asthma / Hay Fever
- Y N Blood Clotting Problems
- Y N Blood Transfusion
- Y N Bronchitis
- Y N Cancer / Tumor or Growth
- Y N Cardiac Pacemaker
- Y N Chest Pain Upon Exertion
- Y N Color Blindness
- Y N Contact Lenses
- Y N Damaged Heart Valve
- Y N Diabetes
- Y N Emphysema
- Y N Environmental Allergies
- Y N Epilepsy
- Y N Fainting Spells / Seizures
- Y N Fever Blisters / Herpes
- Y N Frequent Headaches
- Y N Frequently Dry Mouth / Sjogren
- Y N Gag Reflex
- Y N Gall Bladder Trouble
- Y N Heart Attack / Stroke
- Y N Heart Disease / Angina
- Y N Heart Murmur
- Y N Hepatitis / Jaundice
- Y N High Blood Pressure
- Y N Hives / Skin Rash
- Y N Joint Replacement
- Y N Kidney / Bladder Trouble
- Y N Liver Disease
- Y N Low Blood Pressure
- Y N Mental Health Problems
- Y N Mitral Valve Prolapse
- Y N Persistent Diarrhea
- Y N Premedicate
- Y N Rheumatic Fever
- Y N Rheumatic Heart Disease
- Y N Sexually Transmitted Disease
- Y N Shortness of Breath
- Y N Sinus Trouble
- Y N Stomach Ulcers
- Y N Thyroid Problems
- Y N Tuberculosis
- Y N Unusual Weight Loss
- Y N Urinate Frequently

Other

- Y N See Scanned Documents: Pt Note

☐ Y ☐ N AIDS/HIV Infection

By signing below, I certify that all of the above information is true to the best of my knowledge.

______________________________ ______________________________

Patient/Guardian Signature **Date**