Welcome to the office of

James D. Prigmore, DDS

Patient's Name _____ ***Date of Birth*** _____

Address _____ ***Social Security #*** _____

City _____ Zip code _____ ***Insurance I.D. #*** _____

E-mail address _____ Home Phone _____

Marital Status: S M D W Cell Phone _____

Minor patient's parent or guardian _____ Work Phone _____

If patient is full time student, name of school _____

Emergency contact _____ Relationship _____

Address _____ Phone # _____

Whom may we thank for referring you to our office? _____

Insurance & Responsible Party Information

Insured's Name _____ ***Date of Birth*** _____

Relationship to Patient: Self Spouse Parent Step-parent Other _____ ***SS#*** _____

Address _____ Home & Cell Phone _____

Employer _____ Work Phone _____

Insurance Company _____ ***Group #*** _____

Ins. Co. Address _____ Ins. co. phone _____

Name of Union _____ Local# _____ Union Phone _____

If you have dual insurance, please complete the following:

Insured's Name _____ ***Date of Birth*** _____

Relationship to Patient: Self Spouse Parent Step-parent Other _____ ***SS#*** _____

Employer _____ Phone _____

Insurance company _____ ***Group #*** _____

Name of Union _____ Local# _____ Union Phone _____

Dental Information

Do your gums bleed when you brush? YES NO

Do you have fear of dental work? YES NO

Do you grind or clench your teeth? YES NO

Are your teeth sensitive to pressure? YES NO

Are your teeth sensitive to heat and cold? YES NO

Are your teeth sensitive to sweets? YES NO

If you could change your smile, what would you do? _____

Date of last dental exam and/or cleaning: _____ Name of previous dentist: _____

What was done at your last dental appointment? _____

Why did you leave your last dentist? _____

_____

Medical Information

Name _____

Are you having pain or discomfort at this time? YES NO
Have you been a patient in the hospital during the past two years? YES NO
Have you been under the care of a medical doctor during the past two years? YES NO
Physician's Name _____ Phone _____

Address _____

Medications

Please list any drugs or medications that you are currently taking, their purpose and the physician who prescribed them:

Drug	Purpose	Doctor

Indicate which of the following you have had or have at present. Circle YES or NO for each item.

Heart Failure	YES	NO	Osteoporosis Therapy	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Hepatitis C	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	S.T.D.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	A.I.D.S.	YES	NO
Arteriosclerosis	YES	NO	Emphysema	YES	NO	Cold Sores/Fever Blisters	YES	NO
Mitral Valve Prolapse	YES	NO	Chronic Cough	YES	NO	Blood Transfusion	YES	NO
Artificial Heart Valve	YES	NO	Tuberculosis	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Asthma	YES	NO	Anemia	YES	NO
Heart Surgery	YES	NO	Hay Fever	YES	NO	Sickle Cell Disease	YES	NO
Cortisone Medicine	YES	NO	Allergies or Hives	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Psychiatric Care	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Cancer	YES	NO	Epilepsy or Seizures	YES	NO
Drug Addiction	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Chemotherapy	YES	NO	Nervousness/Anxiety	YES	NO
Artificial Knee, Hip, etc.	YES	NO	Tumors	YES	NO	Anorexia/Bulimia	YES	NO

Do you have or have you had any disease, condition or problem not listed? If so, please list:

_____

Do you have or have you had an allergy or unusual reaction to the following?

Aspirin	YES	NO	Erythromycin	YES	NO	Allergy to Latex	YES	NO
Penicillin	YES	NO	Other Antibiotics	YES	NO	Darvon	YES	NO
Amoxicillin	YES	NO	Percodan	YES	NO	Codeine	YES	NO
Ampicillin	YES	NO	Valium	YES	NO	Vicodin	YES	NO
						Local Anesthetics	YES	NO
						Sulfa Drugs	YES	NO
						Other _____		

Are you taking birth control pills? YES NO
Are you Pregnant? YES NO _____months
Are you nursing? YES NO
Are you taking or have you ever taken Phen-Fen or Redux? YES NO

_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's (or Guardian's) Signature _____ Date _____

Doctor's Signature _____

Comments: _____