Patient Information

Lindsay J. Metro, DDS

Name: ____

(FIRST) (MI) (LAST)

Address: ____________________ City: ________________ Zip: ________

Date of Birth: ______________ SS #: __________________ Sex: ☐M ☐F

Home Phone: ____________ Cell: ____________ Work: ____________

Email Address: ______________________________________

How do you prefer to be contacted? ☐ Home ☐Cell ☐Work ☐Email

Emergency Contact Name: ________________ Phone Number: ______________

How were you referred to us? ______________________________

Insurance Info:

Company Name: ______________________________________

Subscriber Info: Name: ____________________ DOB: ______________

Member ID/SSN: ______________________________

Mailing Address: ______________________________

Please read and initial one (1) of the following:

______ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

______ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

______________________________ ______________

Patient Signature Date

Medical History

Lindsay J. Metro, DDS

Office Use Only BP ______________ HT______________ WT______________ BMI ______________ IV ______________

Patient Name ____ Birth Date ____________________

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ______________________
Have you ever been hospitalized or 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 take, or have you taken, Fen-Phen or Redux? ○ Yes ○ No
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV Positive	YES NO	Cortisone Medicine	YES NO	Hemophilia	YES NO	Renal Dialysis	YES NO
Alzheimer's Disease	YES NO	Diabetes	YES NO	Hepatitis A	YES NO	Rheumatic Fever	YES NO
Anaphylaxis	YES NO	Drug Addiction	YES NO	Hepatitis B/C	YES NO	Rheumatism	YES NO
Anemia	YES NO	Easily Winded	YES NO	Herpes	YES NO	Scarlet Fever	YES NO
Angina	YES NO	Emphysema	YES NO	High Blood Pressure	YES NO	Shingles	YES NO
Arthritis/Gout	YES NO	Epilepsy or Seizures	YES NO	Hives/Rash	YES NO	Sickle Cell Disease	YES NO
Artificial Heart Valve	YES NO	Excessive Bleeding	YES NO	Hypoglycemia	YES NO	Sinus Troubles	YES NO
Artificial Joint	YES NO	Excessive Thirst	YES NO	Irregular Heartbeat	YES NO	Spina Bifida	YES NO
Asthma	YES NO	Fainting/Dizziness	YES NO	Kidney Problems	YES NO	GI Disease	YES NO
Blood Disease	YES NO	Frequent Cough	YES NO	Leukemia	YES NO	Stroke	YES NO
Blood Transfusion	YES NO	Frequent Diarrhea	YES NO	Liver Disease	YES NO	Swelling of Limbs	YES NO
Breathing Problem	YES NO	Frequent Headaches	YES NO	Low Blood Pressure	YES NO	Thyroid Disease	YES NO
Bruise Easily	YES NO	Genital Herpes	YES NO	Lung Disease	YES NO	Tonsillitis	YES NO
Cancer	YES NO	Glaucoma	YES NO	Mitral Valve Prolapse	YES NO	Tuberculosis	YES NO
Chemotherapy	YES NO	Hay Fever	YES NO	Pain in Jaw Joints	YES NO	Tumors/Growths	YES NO
Chest Pains	YES NO	Heart Attack/Failure	YES NO	Parathyroid Disease	YES NO	Ulcers	YES NO
Cold Sores/Fever Blisters	YES NO	Heart Murmur	YES NO	Psychiatric Care	YES NO	Venereal Disease	YES NO
Congenital Heart Disease	YES NO	Heart Pacemaker	YES NO	Radiation Treatment	YES NO	Yellow Jaundice	YES NO
Convulsions	YES NO	Heart Disease	YES NO	Recent Weight Loss	YES NO		

Have you been hospitalized within 5 years? ○ Yes ○ No If yes, please explain: ______________________________
Please list any known drug allergies: ____
General health issues: ____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
Signature of Patient, Parent or Guardian: ______________________________ Date: ______________

Signature of Doctor: ______________________________________ Date: ______________