Jeffrey L. Angart DDS
240 B Market Street
New Albany, Ohio 43054
(614) 775-0840

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ I like to be called:_____
FIRST MI LAST

Address_____City_____State_____Zip Code_____

Home Phone _____ Work Phone _____Cell Phone _____

Which Number is the best to reach you at? (Please Circle) Home Work Cell No Preference

Soc. Sec. # _____ Birthday _____E-Mail _____

Patient /Spouse/Parents Employer_____ Work Number _____

Business Address _____City_____ State_____ Zip Code_____

Name of School/College _____City _____State_____
(IF PATIENT IS STUDENT)

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

IN CASE OF AN EMERGENCY: WHO SHOULD BE NOTIFIED?

Name_____ Relationship_____

Best number to reach them at:_____ _____

MEDICAL INSURANCE INFORMATION

Name of Insurance Company _____ Address_____

Insurance Phone_____Policy Members ID/SSN_____

Relationship to patient: Self_____ Spouse_____Parent_____Other_____Date of Birth_____

Policy Holders Full Name: _____ _____ Policy Holders ID/ SSN Number_____

Policy Holders Employer Name:_____

DENTAL INSURANCE

Dental Insurance _____ Insurance Address_____

Insurance Phone_____ Insured Name_____DOB_____Relationship_____

Member ID/SSN number_____ Policy/Group Number_____

PATIENT DENTAL HISTORY

Previous Dentist _____ Date of last dental visit_____
How often did you visit before that _____
What was done at your last visit _____
Did you have X-rays _____
When was your last dental cleaning _____
How often do you brush? _____ How often do you floss? _____
Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

Please indicate if you have had any of the following:

____ Bad Breath	____ Food Collection between teeth	____ Orthodontic Treatment
____ Bleeding Gums	____ Grinding or Clenching Teeth	____ Periodontal Treatment
____ Cigarette, Cigar or Pipe	____ Headaches	____ Root Canal Treatment
____ Chew tobacco	____ Sore muscle in jaw or side of head	____ Jaw Pain or Tiredness
____ Earaches or Ear ringing	____ Loose Teeth or broken Fillings	____ Clicking and Popping Jaw

PATIENT MEDICAL HISTORY

Physician _____ Office phone _____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No
3. Are you taking any medications at his time? Yes No
   If yes, please list:_____
   _____

Has your physician ever indicated that you should have Pre-Medication before dental treatment? Yes No

5. Are you allergic to any of the following?
   ____ASPIRIN ____LOCAL ANESTHETICS
   ____CODEINE ____PENICILLIN
   ____IODINE ____SULFA
   ____LATEX ____OTHER _____
   Any Other Drug Allergies?_____

6. WOMEN ONLY

A: Are you Pregnant? Yes No
B: Are you nursing? Yes No
C: Are you taking Birth Control? Yes No

7. Please indicate if you have experienced any of the following:

____AIDS/HIV	____Epilepsy/Seizures	____Respiratory disease
____Anemia	____Fainting or Dizziness	____Shortness of Breath
____Arthritis, Rheumatism	____Artificial Heart Valve	____Sinus Condition
____Artificial Joints	____Heart Condition	____Stroke
____Bleeding abnormally (from surgery or extractions)	____Hepatitis Type___	____Swollen Neck Glands
	____Herpes	____Thyroid Problems
____Cancer	____High/Low Blood Pressure	____Tuberculosis
____Chemical Dependency	____Kidney Condition	____Typhoid Fever
____Circulatory (Blood) problems	____Liver Condition	____Rheumatic Fever
____Cortisone Treatments	____Pacemaker	____Ulcer
____Cough, Persistant or Bloody	____Psychiatric care	____Unexplained weight loss
____Diabetes Type ___ A1C____	____Radiation Treatment	____Venereal Disease
____Pre-Diabetic A1C_____		

Blood Pressure_____/_____ (Office use only)

PHOTOGRAPHIC RELEASE

Your initials indicate your consent for Center for Dental Health to use, reproduce and publish photographic/computer illustrations of your teeth/mouth for illustrative and educational purposes. It is not mandatory and is done freely and voluntarily.
Patient Initial _____

AUTHORIZATION

I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information that appears on these dental and medical histories is correct and to the best of my knowledge. I understand that this information will be held in the strictest confidence.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____