

Community Form PATIENT INFORMATION RECORD

Please bring to dental appointment

NAME: _____ Dr. Ms Mrs. Miss Mr.

Male _____ Female _____

BIRTH DATE ____ / ____ / ____
YEAR MONTH DAY

ADDRESS: _____

TELEPHONE. No. _____ PHYSICIAN: _____

CONTACT _____ Relationship _____

HOME: (____) _____ BUSINESS: (____) _____

MEDICATION LIST (Please list **ALL** medications, including non prescription drugs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

ALLERGIES: _____

For patients on Warfarin (Coumadin): **Most recent INR** Date: _____ Reading: _____

ADDITIONAL INFORMATION FOR PATIENTS WITH CAREGIVERS:

MOBILITY:

Does patient use: Wheelchair _____ Walker _____

Able to transfer to dental chair:

NO YES with minimal assistance with 2 persons assisting

COGNITIVE/SENSORY STATUS:

Alert ____ Mildly confused ____ Moderately confused ____ Advanced cognitive impairment ____

Hard of hearing NO YES mild ____ moderate ____ profound ____

Please answer the following questions:

REASON FOR VISIT _____

Last dental visit _____

Radiographs available _____