

Hospital Facility PATIENT INFORMATION RECORD

Please fax to _____ prior to appointment date

NAME: _____ Dr. Ms Mrs. Miss Mr.

Male _____ Female _____ BIRTH DATE ____ / ____ / ____
YEAR MONTH DAY

ADDRESS: _____

UNIT/FLOOR: _____ TELEPHONE. No. _____

PHYSICIAN: _____ PRIMARY CARE NURSE: _____

SDM: _____

HOME: (____) _____ BUS: (____) _____ CELL: (____) _____

ALTERNATE CONTACT _____

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

INSURANCE: NO YES _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: _____

ADDRESS: _____

REASON FOR REFERRAL/VISIT:

MEDICATION LIST (Please list ALL medications, including non prescription drugs OR attach MARS)

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

ALLERGIES:

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:

1. Is patient in pain? Yes ____ No ____

2. Does patient have an acute infection? Yes ____ No ____ If yes, describe location of pain/infection and if pain is intermittent or constant, and duration of pain.

3. What treatment for pain relief/infection has been used?