8105 Gladys Ave.
Beaumont, Texas 77706

HARRISON LUKE, DDS
RESTORATIVE + FAMILY DENTISTRY

409.866.2843
www.harrisonlukedds.com

PATIENT INFORMATION FORM

Date ______________

Last Name: ______________ First Name: ______________ Middle Initial: ______
Preferred Name: ______________ Referred By: ______________
Address: ______________
City: ______________ State: ______________ Zip: ______________
Home Phone: ______________ Cell Phone: ______________ ❒ I would like to receive correspondence via text message
Birth Date: ______________ Social Security: ______________ Sex: ❒ Male ❒ Female
Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed
Employer: ______________ Preferred Pharmacy: ______________

RESPONSIBLE PARTY

❒ Check if same as above
Last Name: ______________ First Name: ______________ Middle Initial: ______________
Address: ______________
City: ______________ State: ______________ Zip: ______________
Home Phone: ______________ Cell Phone: ______________

Emergency Contact
Name: ______________ Phone: ______________ Relationship: ______________

Dental INSURANCE INFORMATION

❒ Check if no insurance
Name of Insured: ______________ Employer: ______________
Relationship to Insured: ❒ Self ❒ Spouse ❒ Child ❒ Other
Insured Social Security: ______________ Insured Birth Date: ______________

Insurance Company: ______________ Employer ID: ______________ Group # ______________
Address: ______________ City: ______________ State: ________ Zip: ________

MEDICAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems

Are you now under the care of a physician? ❒ Yes ❒ No ❒ DK

Physician Name

Phone: *Include area code*
(   )

Previous surgeries or hospitalizations:

Medications currently taking:
____
____
____
____
____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❒ Yes ❒ No ❒ DK Date: ___________ If yes, have you had any complications? __________	Do you use tobacco (smoking, snuff, chew)? ❒ Yes ❒ No ❒ DK
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or resdronate (Actonel®) for osteoporosis or Paget's disease? ❒ Yes ❒ No ❒ DK	Are you taking blood thinners? ❒ Yes ❒ No ❒ DK If yes, which medication? ________________________
Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia of skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ❒ Yes ❒ No ❒ DK Date Treatment began:__________________________	**WOMEN ONLY** Are you: Pregnant? ❒ Yes ❒ No ❒ DK Number of weeks: ________________________ Taking birth control pills or hormonal replacement? ❒ Yes ❒ No ❒ DK Nursing? ❒ Yes ❒ No ❒ DK

Allergies - Are you allergic to or have you had a reaction to:

Local anesthetics ❒ Yes ❒ No ❒ DK
Aspirin ❒ Yes ❒ No ❒ DK
Penicillin or other antibiotics ❒ Yes ❒ No ❒ DK
Barbiturates, sedatives, or sleeping pills ❒ Yes ❒ No ❒ DK
Codeine or other narcotics ❒ Yes ❒ No ❒ DK
Metals ❒ Yes ❒ No ❒ DK
Latex (rubber) ❒ Yes ❒ No ❒ DK

Condition	Yes	No	DK
Abnormal bleeding	❒ Yes	❒ No	❒ DK
Anemia	❒ Yes	❒ No	❒ DK
Arthritis	❒ Yes	❒ No	❒ DK
Artificial (prosthetic) heart valve	❒ Yes	❒ No	❒ DK
Asthma	❒ Yes	❒ No	❒ DK
Autoimmune disease	❒ Yes	❒ No	❒ DK
Bronchitis	❒ Yes	❒ No	❒ DK
Cancer/Chemotherapy			
Radiation treatment	❒ Yes	❒ No	❒ DK
Cardiovascular disease	❒ Yes	❒ No	❒ DK
Chronic pain	❒ Yes	❒ No	❒ DK
Congenital heart disease (CHD)	❒ Yes	❒ No	❒ DK
Unrepaired, cyanotic CHD	❒ Yes	❒ No	❒ DK
Repaired (completely) in last 6 months	❒ Yes	❒ No	❒ DK
Repaired CHD with residual defects	❒ Yes	❒ No	❒ DK
Congestive heart failure	❒ Yes	❒ No	❒ DK
Damaged heart valves	❒ Yes	❒ No	❒ DK
Diabetes	❒ Yes	❒ No	❒ DK
Eating Disorder	❒ Yes	❒ No	❒ DK
Emphysema	❒ Yes	❒ No	❒ DK
Epilepsy	❒ Yes	❒ No	❒ DK
Fainting spells or seizures	❒ Yes	❒ No	❒ DK
G.E.Reflux/persistent heartburn	❒ Yes	❒ No	❒ DK
Gastrointestinal disease	❒ Yes	❒ No	❒ DK
Glaucoma	❒ Yes	❒ No	❒ DK
Heart attack	❒ Yes	❒ No	❒ DK
Hepatitis, jaundice or liver disease	❒ Yes	❒ No	❒ DK
High blood pressure	❒ Yes	❒ No	❒ DK
HIV / AIDS	❒ Yes	❒ No	❒ DK
Kidney problems	❒ Yes	❒ No	❒ DK
Low blood pressure	❒ Yes	❒ No	❒ DK
Mental health disorders	❒ Yes	❒ No	❒ DK
Mitral valve prolapse	❒ Yes	❒ No	❒ DK
Neurological disorders	❒ Yes	❒ No	❒ DK
Obstructive Sleep Apnea	❒ Yes	❒ No	❒ DK
Osteoporosis	❒ Yes	❒ No	❒ DK
Pacemaker	❒ Yes	❒ No	❒ DK
Previous infective endocarditis	❒ Yes	❒ No	❒ DK
Rheumatic fever	❒ Yes	❒ No	❒ DK
Rheumatic heart disease	❒ Yes	❒ No	❒ DK
Rheumatoid arthritis	❒ Yes	❒ No	❒ DK
Severe headaches/migraines	❒ Yes	❒ No	❒ DK
Sexually transmitted disease	❒ Yes	❒ No	❒ DK
Stroke	❒ Yes	❒ No	❒ DK
Systemic lupus erythematosus	❒ Yes	❒ No	❒ DK
Thyroid problems	❒ Yes	❒ No	❒ DK
Tuberculosis	❒ Yes	❒ No	❒ DK

Do you require antibotics prior to your dental treatment? ❒ Yes ❒ No ❒ DK

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think the doctor should know about? ❒ Yes ❒ No ❒ DK
Please explain:

Signature of Patient/Legal Guardian: ____ **Date:** ______________________