PATIENT HISTORY & INFORMATION

Today's Date: _____

Circle one – Mr Mrs Miss Ms Dr

Birth Date: _____

NAME _____ Age: _____ Sex: _____ Marital Status: _____
LAST FIRST MIDDLE

ADDRESS _____ Email Address:_____
NUMBER, STREET, CITY STATE/ZIP

Home Phone #: ( )_____ Pager/Mobile #: ( ) _____ Work Phone #: ( ) _____ ext._____

EMPLOYER: _____ Occupation: _____ Social Security No.: _____

Nearest Relative in area: _____ Address: _____ Phone: ( ) _____

Who referred you to our office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT
( ) Self ( ) Other _____ Relation: _____

Billing Address: _____

INSURANCE INFORMATION

Subscriber: _____ Social Security #: _____ Subscriber's Date of Birth: _____

Employer: _____ Dental Insurance Company & Policy No._____

MEDICAL/DENTAL HISTORY -
Medical Doctor: _____ Address/City/State: _____ Phone: _____

When did you last consult a physician? _____ Reason: _____

Have you been a patient in a hospital in the past 2 years? Yes No Reason: _____

Name of former dentist: _____ Date of last dental examination:_____

Are you under a physician's care now? Yes No Are you having dental discomfort now? Yes No

Do you have, or have you had, any of the following (Please circle yes or no for each question)

1. Heart Disease ..... Yes No
2. High Blood Pressure..... Yes No
3. Blood Disease ..... Yes No
4. Rheumatic Fever..... Yes No
5. Heart Murmur..... Yes No
6. Diabetes..... Yes No
7. Stroke ..... Yes No
8. Epilepsy..... Yes No
9. Fainting..... Yes No
10. Psychiatric Treatment..... Yes No
11. Arthritis..... Yes No
12. Tumor History..... Yes No
14. Radiation Treatment..... Yes No
15. Liver or Kidney Disease ..... Yes No
16. Hepatitis, Jaundice ..... Yes No
17. Allergies..... Yes No
    a. Penicillin..... Yes No
    b. Other Antibiotics ..... Yes No
    c. Local Anesthetic ..... Yes No
    d. Latex ..... Yes No
18. Asthma..... Yes No
19. Respiratory Disease ..... Yes No
20. Does your jaw "click" or hurt? ..... Yes No
21. Are you pregnant? ..... Yes No

22. List current medications/supplements:

23. Have you had excessive bleeding requiring treatment? ..... Yes No
24. Have you experienced any unfavorable reaction to previous dental treatment? .... Yes No
25. Have you ever taken Phen Fen diet pills? ..... Yes No

25. In case of emergency, who should be notified?

Name: _____ Relation: _____ Phone #:_____

ACKNOWLEDGEMENT AND AUTHORITY
I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department.

Signature:_____ Reviewed by:_____
PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

Date:_____