

PATIENT INFORMATION (CONFIDENTIAL)

Patient # _____

Date _____

NAME _____ SEX: M F AGE _____
FIRST MI LAST

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ BIRTHDATE _____

SOC. SEC. # _____ MEDICARE # _____ MEDICAID # _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED STUDENT

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

DENTIST NAME _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SOC. SEC. # _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION**Primary Dental**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ UNION OR LOCAL # _____ WORK PHONE _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

INSURANCE COMPANY _____ INS. CO. PHONE # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

GROUP # _____ POLICY ID # _____

Primary Medical

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ UNION OR LOCAL # _____ WORK PHONE _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

INSURANCE COMPANY _____ INS. CO. PHONE # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

GROUP # _____ POLICY ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE OTHER SIDE

Signature of Patient or Parent if Minor X _____

Patient Name _____

Patient # _____

MEDICAL HISTORY

(This information is Very Important And Accurate Answers Are Essential)

In order to PROTECT your health, the health of the staff and minimize the risk of infection, we ask that you answer the following health related questions. Proper answers to these questions will allow us to provide you with better treatment.

Have you ever had/or do you have any of the following? PLEASE CIRCLE THE APPROPRIATE ANSWER.

YES NO Do you have a current medical problem? If so, what? _____

- | | | |
|--------------------------------------|----------------------------|-------------------------|
| YES NO Heart Trouble | YES NO Shortness of Breath | YES NO Convulsions |
| YES NO Rheumatic Fever | YES NO Asthma | YES NO Fainting Spells |
| YES NO High Blood Pressure | YES NO Emphysema | YES NO Anemia |
| YES NO Swelling of Ankles | YES NO Tuberculosis | YES NO Allergy to Eggs |
| YES NO MVP (Mitral Valve Prolapse) | YES NO Chronic Cough | YES NO Allergy to Soy |
| YES NO Prosthetic (Artificial) Joint | YES NO Hearing Aids | YES NO Allergy to Latex |
| YES NO Wear Contact Lenses | YES NO Nervous Disorders | YES NO Allergy to Sulfa |

YES NO To your knowledge have you ever been exposed to the HIV virus? _____

YES NO Do you have or suspect you may have AIDS? _____

YES NO Have you had any jaw joint problems (TMJ) of clicking, popping, pain or limited mobility? _____

YES NO Have you ever taken CORTISONE or ACTH? _____

YES NO Have you ever taken anticoagulants (blood thinners)? _____

YES NO Are you taking tranquilizers, sedatives or antidepressants? _____

YES NO Have you ever taken heart or high blood pressure medicine? _____

YES NO ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE? Please list _____

YES NO ARE YOU DIABETIC? How do you control your sugar level? _____

YES NO ARE YOU ALLERGIC TO ANY FOOD, MEDICINE, or DRUG? If so, what? _____

YES NO Have you had hives, wheezing or a rash after taking medicines? If yes, which medicines? _____

YES NO Have you had prolonged bleeding following an injury or surgery? _____

YES NO Do you have a COLD, COUGH, RUNNY NOSE, OR SORE THROAT? _____

YES NO Do you smoke a pack or more of cigarettes a day? How long? _____ years

YES NO Have you been under the care of a physician during the past year? If so, FOR WHAT? _____

Physician Name _____ Phone _____

Specialist Name _____ Phone _____

YES NO Have you ever had HEPATITIS (liver trouble)? Or jaundice? When? _____

YES NO Have you ever had MAJOR SURGERY? If yes, WHAT AND WHEN? _____

YES NO If female, are you PREGNANT? YES NO Are you Nursing?

YES NO Have you ever received Radiation / Chemotherapy?

YES NO IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD?
(narcotics use, pregnancy, alcoholism, tumors, psychiatric care, chemical detoxification, etc.) _____

Reviewed by: Doctor _____ Date _____

I certify that I have answered the above questions truthfully (to the best of my knowledge).

Date

Patient Signature or relative where required