PATIENT INFORMATION (CONFIDENTIAL)

Date: ___________________

Pt's Legal First Name _______________________M.I._______ Last_____________________________________

Name Called______________________________________ Birth date ______/______/________ Age_________

Street Address_______________________________________City/St_______________________Zip __________

Home Phone ________________________Cell Phone______________________ Work Phone________________

Social Security #__________________________ Employer____

Married _______ Single_______ Divorced_______ Widowed_______ Female_______ Male_______

Student: Full Time_____ Part Time______ School Name/Address______________________________________

RESPONSIBLE PARTY (If different from above)**:**

Name____ Relationship to patient___________________

Street Address______________________________________City/St_______________________Zip___________

Home Phone_________________________ Cell Phone_____________________ Work Phone________________

Employer Name/Address____

For **MINOR** children:

Mothers Name____ Social Security#____________________________

Fathers Name____ Social Security#____________________________

INSURANCE INFORMATION:

- Medical____ Dental____

Insurance Co. ____ Phone#__________________________

Policy Holder Name___________________________ Birth date_____/____/_____ Relationship____________

ID/SSN_______________________________________ Group#____

Employer____ Employer Phone______________________

- Medical____ Dental____

Insurance Co.____ Phone#__________________________

Policy Holder Name__________________________ Birth date ____/____/_____ Relationship______________

ID/SSN______________________________________Group#____

Employer____ Employer Phone______________________

- Medical ____ Dental____

Insurance Co.____ Phone#____________________________

Policy Holder Name__________________________ Birth date _____/_____/_____ Relationship_____________

ID/SSN______________________________________Group#____

Employer____ Employer Phone_________________________

MEDICAL HISTORY

Patient's Height ______________ **Weight**_____________

Dentist Name/Phone #____

Physician Name/Phone #____

Date of Last Medical Exam ___________________________ **Reason**________________________________

Current Medical Problems ____

____

Current Medications ____

Previous Surgeries or Hospitalizations ____

____

Problems with General Anesthesia ____

Known Allergies (Check all that apply): Local Anesthetic________ Aspirin ________ Codeine __________
Sulfa Drugs _________ Penicillin ________ Other Drugs ____

Medical Problems (Check any that apply):

_____Heart Disease
_____Heart Attack
_____Angina Pectoris
_____High Blood Pressure
_____Heart Murmur
_____Rheumatic Fever
_____Respiratory Disease
_____Asthma
_____Tuberculosis
_____Bronchitis
_____Emphysema
_____Diabetes
_____Kidney Disease
_____Venereal Disease
_____TMJ Problems
_____Thyroid

_____Bleeding Problems
_____Blood Thinner
_____Anemia
_____Hepatitis/Liver Disease
_____Immune Deficiency
_____AIDS/HIV
_____Convulsions/Seizures
_____Cancer (Type)___________________
_____Stroke
_____Glaucoma
_____Arthritis
_____Stomach Ulcers
_____Psychiatric Condition
_____Collagen/Vascular Disease
_____Neck Injury/Problems
_____Osteoporosis

Have you ever had radiation treatment for any reason? _____Yes _____No Reason_______________

Do you smoke? _____Yes _____No If yes, how much per day ____________________________

Females: Are you pregnant? _____Yes _____No

Who may we thank for referring you to our practice? ____