PATIENT INFORMATION

PLEASE PRINT

DATE ____________

☐ Married ☐ Single ☐ Widow ☐ Male ☐ Female

NAME ____________ Height ____' ____" Weight ____ lbs.

ADDRESS(HOME) ____________
Street Apt # City State Zip

ADDRESS(MAILING) ____________
Street Apt # City State Zip

BIRTHDATE ____________ AGE ____________ TELEPHONE ____________
Home Work

PLACE OF EMPLOYMENT: ____________ S.S.# ____________

DENTAL INSURANCE CO.: ____________ MEDICAL INS. ____________

Has any member of your family ever been treated in our office? ☐ No ☐ Yes (Name) ____________

FAMILY INFORMATION

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name:	Last First MI	Last First MI
Address:	Street City State Zip	Street City State Zip
Telephone #:	Home # Work #	Home # Work #
Birthdate/SS #:	Month Day Year SS #	Month Day Year SS #
Employer:	Employer	Employer
Dental Insurance Co.: Group #:	Dental Insurance Group #	Dental Insurance Group #

Payment due at time of service. Cash • Check • Visa • MasterCard

Who Will Pay Account: ____________ Relation to Patient: ____________

Address: ____________ Phone: ____________

Referred By: ____________ Family MD ____________ Family Dentist: ____________

Check for Yes		Check for Yes	
____	HIV Positive (AIDS)	____	Are you prone to fainting?
____	Pregnant Now	____	Allergies
____	Asthma	____	Bleeding Disorders
____	Hay Fever	____	Rheumatic Fever
____	Lung Disease	____	Heart Trouble (Attack)
____	Liver Disease (Jaundice, Hepatitis)	____	Heart Murmur
____	Kidney Disease	____	Pacemaker
____	High Blood Pressure	____	Artificial Joints or Valves
____	Frequent Swollen Ankles	____	Chest Pain
____	Shortness of Breath	____	Anemia
____	Venereal Disease	____	Convulsions
____	Diabetes	____	Stroke
____	Arthritis	____	Do you bruise easily?

Check for Yes

____ Are you under a physician's care at present? . . . .

____ Are you allergic to any food, drug or medicine . . . .

____ Have you been told not to take some drug penicillin, sulfa, aspirin, novocaine, etc? . . . .

____ If so, what? ____________ . . . .

____ Have you or your relatives had a bad reaction to anesthesia? . . . .

____ Are you taking any pills, drugs or medications at present?

____ If so, what? ____________ . . . .

____ Have you ever been hospitalized? . . . .

____ Have you ever been put to sleep for an operation? . . . .

____ Have you ever had radiation therapy? . . . .

____ Have you ever taken cortisone, ACTH, or other steroid? . . . .

____ Do you smoke? If so, how much? ____________ . . . .

____ Do you wear contact lenses? . . . .

____ Have you ever had problems with your jaw joints (clicking, locking, etc.)? . . . .

Medical History Notes: ____________

I hereby authorize the release of my records to my insurance company, Physician, or Dentist as deemed necessary in the professional judgment of my Oral Surgeon. I assume Financial Responsibility for ALL Services and Charges Incurred and authorize payment of benefits to the oral surgeon.

____________ ____________ ____________

Date **Patient/Other Legally Responsible Person/Relationship** **State Driver's License Number**