PATIENT INFORMATION

DATE:_____

NAME:_____ ❑ MARRIED ❑ SINGLE ❑ WIDOWED ❑ MALE ❑ FEMALE
LAST FIRST M

ADDRESS:_____
STREET APT. # CITY STATE ZIP

BIRTH DATE:_____ PHONE (S):_____
MO/DAY/YR HOME CELL WORK

PATIENT'S EMPLOYER:_____ S.S. #_____

SPOUSE OR PARENT NAME:_____ EMPLOYER:_____

HOUSEHOLD MEMBER(S) PREVIOUSLY TREATED IN OUR OFFICE _____

Whom may we thank for referring you to our office?_____

INSURANCE INFORMATION

Please present Insurance Card so that we may obtain copy and contact your insurance company for benefits.

MEDICAL HISTORY

Medical doctor's name_____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Are you taking any medications, pills, or drugs? What? _____ YES NO

Are you allergic to any medications or substance? What? _____ YES NO

Are you pregnant? (women) _____ YES NO

Please CIRCLE if you have had any of the following:

Heart trouble	Chest Pain	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Asthma	Thyroid Disease	Psychiatric Care
Low Blood Pressure	Swelling of Feet /Ankles/Hands	Hay Fever	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Rheumatic Fever	Stroke	Emphysema	Chemotherapy/Radiation	Hemophilia
Congenital Heart Lesion	Diabetes	Frequent cough	Arthritis/Gout	AIDS
Artificial Heart Valve	Excessive Thirst	Lung Disease	Rheumatism	Venereal Disease
Heart Pacemaker	Artificial Joints/Hips	Tuberculosis	Pain in Jaw Joints	Cold Sores
Heart Surgery	Kidney Trouble	Liver Disease	Cortisone Medicine	Fever blisters
Blood Disease	Ulcers	Hepatitis A (infec.)	Glaucoma	Herpes
Anemia	Allergies	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
		Yellow Jaundice	Nervousness	Sickle Cell Anemia

Have you ever had any other serious illness not listed above?_____ YES NO

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X_____ DATE_____

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or Wife) ❑ Guardian

DATE	CHANGES IN MEDICAL HISTORY/MEDICATION TAKEN	PATIENT'S SIGNATURE