

PATIENT INFORMATION SHEET

Please complete all pages of this form. All information is confidential.

1. PERSONAL INFORMATION

DATE: _____

PatientName _____ Sex M/F

Address _____

City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____ Cell Phone () _____

Age _____ Birthdate _____ Social Security No. _____

Driver License No. _____ E-Mail Address _____

Employer Business Address _____

Occupation _____

Marital Status (circle one) Married Single Divorced Widowed

School/City (if you are less than 25 years old) _____

Spouse's Name _____

Employer _____ Business Phone () _____

Business Address _____

Occupation _____

Person responsible for account (if minor or different than the patient)

Name _____ Driver License No. _____

Home Phone () _____ Business Phone () _____

Address _____

Social Security No. _____

2. GETTING TO KNOW YOU

Do you have a Nick Name? _____

Referred to us by _____ Convenient Appointment Time _____

Person to contact for emergency _____ Day Phone () _____

Are you available for appointments on short notice? Yes _____ No _____

3. DENTAL INSURANCE

Primary Insurance Co. _____ Group No. _____

Person Carrying Insurance _____ SS#/I.D.# _____

Employed at _____ Date of Birth _____

Address _____ Phone () _____

Secondary Insurance Co. _____ Group No. _____

Person Carrying Insurance _____ SS# / I.D. # _____

Employed at _____ Date of Birth _____

Address _____ Phone () _____

Medical Information

1. Are you having pain or discomfort at this time? _____ YES NO
2. Have you been a patient in the hospital during the past two years? _____ YES NO
3. Have you been under the care of a medical doctor during the past two years? _____ YES NO
 Physician's Name _____ Phone No. () _____
 Address _____
4. Have you taken any medication or drugs during the past two years? _____ YES NO
5. Are you now taking any medication or anesthetics? _____ YES NO
 If yes, please list: _____
6. Are you sensitive to any medication or anesthetics? _____ YES NO
 If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints	YES	NO	Latex Allergy	YES	NO
Heart Disease/Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis C	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Stent (Brain or Heart)	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Sinus Trouble	YES	NO	Epilepsy/Seizures	YES	NO
Rheumatism	YES	NO	Radiation Therapy	YES	NO	Fainting/Dizzy Spells	YES	NO
Cortison Medicine	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Hepatitis A	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis B	YES	NO	Dev.Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? _____ YES NO
9. Do your ankles swell during the day? _____ YES NO
10. Do you use more than two pillows to sleep? _____ YES NO
11. Have you lost or gained more than 10 pounds in the past year? _____ YES NO
12. Do you ever wake up from sleep and feel short of breath? _____ YES NO
13. Are you on a special diet? _____ YES NO
14. Do you have or have you had any disease, condition or problem not listed? _____ YES NO
 a. If yes, please list: _____
15. Have you ever taken Fen-Phen or Redux? _____ YES NO

FOR WOMEN ONLY:

Are you pregnant? _____ Yes, what month? _____ No _____ Are you nursing? _____ Yes _____ No Are you taking birth Control pills? _____ Yes _____ No

CONSENT:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the Heart Failure _____
YES NO Artificial Joints _____ YES NO Latex Allergy _____ YES NO
Heart Disease/Attack __ YES NO Kidney Trouble _____ YES NO Hepatitis C _____ YES NO
Angina Pectoris _____ YES NO Ulcers _____ YES NO Venereal Disease _____ YES NO
Congenital Heart Disease

2. patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____
I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed to fit to provide recommended treatment.
4. Lastly, I understand that where appropriate, **credit bureau** reports may be obtained.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party _____ Relationship to Patient _____