

# PATIENT INFORMATION

**Note:** The information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts.

BIRTHDAY \_\_\_\_\_ SEX  M  F

NAME \_\_\_\_\_ Age \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

PHONE \_\_\_\_\_ SS # \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE?  Yes  No

INSUROR \_\_\_\_\_

NAME OF INSURED EMPLOYEE \_\_\_\_\_

POLICY # \_\_\_\_\_

WHO RECOMMENDED YOU TO THIS OFFICE? (Name) \_\_\_\_\_

DATE OF LAST CLEANING \_\_\_\_\_ LAST X-RAYS \_\_\_\_\_

Are you now under the care of a physician? Yes  No   
(If yes, please explain) \_\_\_\_\_

Are you now taking any drug or medicine? Yes  No   
(Please List) \_\_\_\_\_

Have you been hospitalized in the last two years? Yes  No   
(If yes, please explain) \_\_\_\_\_

Are you allergic or sensitive to ANYTHING? Yes  No   
(Drugs, dental anesthetics, penicillin, etc. - Please List) \_\_\_\_\_

Have you ever taken cortisone or steroids? Yes  No

Do you get out of breath easily? Yes  No

Do your ankles often swell? Yes  No

Do you smoke? Yes  No

Females only: Are you pregnant? Yes  No

Do you have or have you had? (Check)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart trouble       | <input type="checkbox"/> Bleeding problem      | <input type="checkbox"/> Stomach, intestinal trouble    |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Circulatory problems           |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Venereal disease      | <input type="checkbox"/> Blood disease                  |
| <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Eye, ear, nose, throat trouble |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Thyroid disease       | <input type="checkbox"/> Hepatitis                      |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fainting spells       | <input type="checkbox"/> Sinus trouble                  |
| <input type="checkbox"/> Strep Throat        | <input type="checkbox"/> X-Ray Therapy         | <input type="checkbox"/> Kidney disease                 |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Severe Headaches               |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Mitral Valve Prolapse |   |

Indicate any disease, condition or problem not listed above that you think I should know about.

**REMARKS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs and all reasonable attorney fees incurred in the collection of those fees.

Patient (Parent) \_\_\_\_\_ Date \_\_\_\_\_

Doctor \_\_\_\_\_ Date \_\_\_\_\_