

PATIENT INFORMATION AND MEDICAL HISTORY

DATE _____

NAME _____ LAST FIRST M MARRIED SINGLE MINOR MALE FEMALE

SS# _____

ADDRESS _____ STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____ HOME# WORK# FAX# E-MAIL#
MONTH DAY YEAR

PLACE OF EMPLOYMENT _____ ADDRESS _____

EMPLOYER, SCHOOL NAME _____ GRADE _____

RESIDENT FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE OTHER MOTHER

DECLARATION

STATE FOR RESPONSIBLE PARTY

GENERAL CONSENT

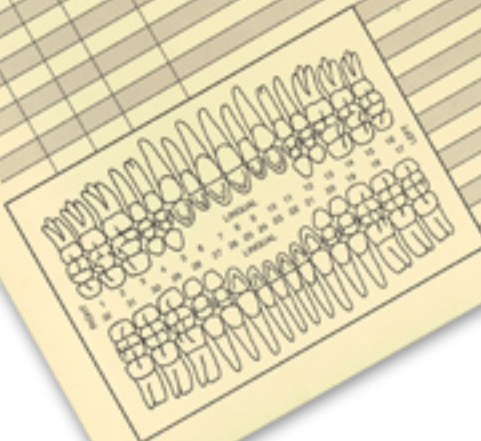
I hereby authorize _____ to use my insurance benefits for dental services performed by _____ responsible for my dental care. I authorize _____ Dental Office to perform the necessary diagnostic, restorative, orthodontic, and other dental services necessary for the proper care of my teeth. I authorize the release of my information to _____ and _____.

ACCOUNT # _____

Provider Signature	ADA Code	Fee

PATIENT NAME

Date	Acc.	Surg. #	Surfaces



- Please check appropriate boxes.
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> X-Ray Treatments (Radiation) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hemophilia (Bleeding Problem) | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Recent Blood Transfusion | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Corticoid Medicine | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Artificial Joint * | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> AIDS | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Allergies (Medicines) |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Allergies (Pollen / Dust) |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Hives or Rash |
| <input type="checkbox"/> Unexplained Fever | <input type="checkbox"/> Bloody Sputum | <input type="checkbox"/> Tattoos | <input type="checkbox"/> Need Premedication? |

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN) _____

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____