PATIENT INFORMATION FORM

Patient
Name_____Married___Single___Minor___
Birthday____/____/____ Full Time Student? _____Yes ____No
Address_____
City_____ State_____ Zip_____
Phone (Home) _____ (Work) _____
Employer_____Social Security #_____
Dental Insurance Company_____ Group #_____
Person Responsible For Account (if other than patient)
Name_____
Address_____
City_____ State_____ Zip _____
Phone (Home) _____ (Work) _____
Employer_____ Social Security # _____
Dental Insurance Company _____ Group # _____
Person to Notify in Case of Emergency:
Name_____
Address_____ Phone _____
City _____ State _____ Zip_____
Medical History

	Yes	No
Are you under any medical treatment now?	___	___
Have you had any major operations? If so, what?	___	___
Are you on a diet at this time?	___	___
Are you taking any drugs or medication?	___	___
Are you in general good health at this time?	___	___
Are you pregnant?	___	___
Do you have a history of fainting?	___	___
Have you ever had any x-ray treatment? (other than diagnostic)	___	___
Have any wounds healed slowly or presented other complications?	___	___
Do you have any night sweats accompanied by weight loss or cough?	___	___
Are you allergic to any known materials that cause hives, asthma, eczema, etc.? What?	___	___

Has a physician ever informed you that you had:

	Yes	No		Yes	No
A heart ailment?	___	___	Tumors or growths?	___	___
High Blood Pressure?	___	___	Any Blood Disease?	___	___
Respiratory Disease?	___	___	Any Liver Disease?	___	___
Diabetes?	___	___	Any Kidney Disease?	___	___
Rheumatic Fever?	___	___	AIDS?	___	___
Rheumatism or Arthritis?	___	___	Venereal Disease?	___	___
Heart Murmur?	___	___	Yellow Jaundice or Hepatitis?	___	___
Stomach or Intestinal Disease?	___	___			

Please List medications!

Patient Dental History

	Yes	No
Do you have any pain in or near your ears?	____	____
Have you had reactions or allergic symptoms to novocaine?	____	____
Have you had any difficult extractions in the past?	____	____
Have you had any prolonged bleeding after extractions?	____	____
Do your gums bleed?	____	____
Have you ever had instruction on the correct method for brushing your teeth?	____	____
Have you ever had any instruction on the care of your gums?	____	____
Do you habitually clench your teeth during the night or day?	____	____
Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.) ?	____	____
Do you at the present time have any dental complaints?	____	____

If so, what?_____

_____

_____

Have you had dental x-rays taken within the last two years?
_____ When?_____

Where were they taken?_____

Has any member of your family been treated in our office before? ____Yes ____ No

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

_____

Method of Payment

Our policy in keeping costs down requires prompt payments. Please check the payment method that you will use.

_____Cash

_____Insurance Co Payment

_____[redacted]

Authorization

I hereby authorize Dr. L. William Veihdeffer to administer such medication and therapeutic procedures as may be necessary for proper dental care. The information on this form is correct to the best of my knowledge.

I have reviewed the following treatment plan, I authorize release of any information relating to this claim. I understand that I am responsible for all costs of my dental treatment.

Signature_____Date_____