DATE_____

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT NAME_____ DATE OF BIRTH_____
LAST FIRST MI

HOME ADDRESS_____
STREET/APT.# CITY STATE ZIP

HOME PHONE_____ SOCIAL SECURITY NUMBER_____

CELL PHONE # _____ EMPLOYER _____

EMPLOYER ADDRESS_____ WORK PHONE_____ EXT._____

SPOUSE NAME_____ EMPLOYER_____

WORK PHONE_____ EXTENSION_____

EMERGENCY CONTACT_____ PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

RESPONSIBLE PARTY

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE_____

IF PATIENT IS A CHILD, NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____ ADDRESS_____

HOME PHONE_____ BIRTHDATE_____ EMPLOYER_____

WORK PHONE_____ IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ___YES ___NO

PATIENT MEDICAL HISTORY

PHYSICIAN_____ PHONE_____ DATE OF LAST EXAM_____

ARE YOU UNDER TREATMENT NOW?____YES____NO

HAVE YOU EVER BEEN HOSPITALIZED FOR A SURGICAL OPERATION OR SERIOUS ILLNESS?____YES____NO

ARE YOU TAKING ANY MEDICATION(S), INCLUDING NON-PRESCRIPTION MEDICINE? ____YES____NO

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

LOCAL ANESTHETICS (NOVACAINE, ETC.) ____YES____NO BARBITURATES____YES____NO

PENICILLIN OR OTHER ANTIBIOTICS ____YES____NO ASPRIRIN ____YES____NO

SEDATIVES____YES____NO SULFA DRUGS____YES____NO IODINE ____YES____NO

OTHER____YES____NO (PLEASE LIST)_____

WOMEN ONLY: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?____YES____NO
ARE YOU NURSING? ____YES____NO
ARE YOU TAKING BIRTH CONTROL PILLS? ____YES____NO