Robert J. McGovern, D.D.S. · Ron Borin, D.D.S., Inc.
312 W. Line St. · Bishop, CA 93514
Telephone: (760)873-3208

HEALTH HISTORY

Name: ______________________ Date: ______________________

Please answer each question:

1. Have you been a patient in a hospital during the past 2 years? ☐ Yes ☐ No
   If yes, explain ______________________
2. Have you been under the care of a physician during the past 2 years? ☐Yes ☐ No
   If yes, explain ______________________
3. Have you taken any medicine or other drugs the past year? ☐ Yes ☐ No
   If yes, list below. ______________________
4. Are you allergic to penicillin, codeine or other drugs or medicine? ☐ Yes ☐ No
   If yes, what ______________________
5. Any other allergies? ☐ Yes ☐ No
   If yes, list ______________________
6. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
   If yes, describe ______________________

Check Any Of The Following You Have Had:

YES	NO	Condition	YES	NO	Condition	YES	NO	Condition
☐	☐	Heart Trouble	☐	☐	Diabetes	☐	☐	Liver Problems
☐	☐	Congenital Heart Lesion	☐	☐	Tuberculosis	☐	☐	Malignancies
☐	☐	Heart Murmur	☐	☐	Hepatitis	☐	☐	Radiation Treatment
☐	☐	High Blood Pressure	☐	☐	Chest Pains	☐	☐	Chemotherapy
☐	☐	Anemia	☐	☐	Arthritis	☐	☐	Fainting or Dizzy Spells
☐	☐	Rheumatic Fever	☐	☐	Stroke	☐	☐	Systemic Lupus
☐	☐	Pacemaker	☐	☐	Epilepsy	☐	☐	Adrenal Gland Disease
☐	☐	Jaundice	☐	☐	Psychiatric Treatment	☐	☐	Thyroid Problems
☐	☐	Asthma	☐	☐	Sinus Trouble	☐	☐	Venereal Disease
☐	☐	Cough	☐	☐	Kidney Problems	☐	☐	Herpes
			☐	☐	Emphysema			

Physician: ______________________ Date of last physical exam: ______________________

7. Have you had any other serious illnesses? ☐ Yes ☐ No
   If yes, describe ______________________
8. Have you experienced any other unfavorable reaction from any previous dental treatment? ☐ Yes ☐ No
   If yes, explain ______________________
9. Have you had any joints replaced or back surgeries? ☐ Yes ☐ No
   If yes, explain ______________________
10. (Women) Are you taking birth control pills? ☐ Yes ☐ No
11. (Women) Are you pregnant now? ☐ Yes ☐ No
    If yes, what month ______________________
12. Do you have AIDS? ☐ Yes ☐ No
13. Have you ever been denied permission to donate blood? ☐ Yes ☐ No
    If yes, why ______________________
14. Do you have a history of TB disease? ☐ Yes ☐ No
15. Have you ever had a persistent cough or throat clearing with no known illness? ☐ Yes ☐ No
16. Have you ever taken the medication Fosamax or Phen Fen? ☐ Yes ☐ No
    If yes, circle which medication and explain ______________________
17. Have you had a recent weight loss not associated with a weight loss program? ☐ Yes ☐ No
    If yes, explain ______________________
18. Have you ever had a lingering fever? ☐ Yes ☐ No
    If yes, explain ______________________
    Is there any medical, physical or emotional condition which Dr. McGovern or Dr. Borin should be made aware of that could adversely influence the results of dental treatment?

PRESCRIPTION DRUGS TAKEN:
NON PRESCRIPTION DRUGS TAKEN:
HERBALS TAKEN:
VITAMINS TAKEN:

PATIENT'S SIGNATURE______________________ DR'S SIGNATURE______________________

PATIENT INFORMATION

DATE ____________________

NAME ______________________________ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST MIDDLE

SOCIAL SECURITY # ____________________ BIRTHDATE ____________________
MONTH DAY YEAR

MAILING ADDRESS ____________________
STREET / P.O. BOX APT. # CITY STATE ZIP

TELEPHONE NUMBER ____________________
HOME WORK CELL EMAIL

NAME OF EMPLOYER ____________________ ADDRESS ____________________

IF FULL TIME STUDENT, SCHOOL NAME ____________________ GRADE __________

PERSON RESPONSIBLE FOR ACCOUNT-PLEASE CHECK ONE: ❑ PATIENT ❑ GUARDIAN ❑ SPOUSE ❑ FATHER ❑ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED (IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY)	SECONDARY INSURED (IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY)
LAST FIRST MIDDLE	LAST FIRST MIDDLE
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL EMAIL	HOME WORK CELL EMAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE COMPANY	EMPLOYER DENTAL INSURANCE COMPANY
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

PATIENT ACKNOWLEDGEMENT

I ____________________, acknowledge I have Received from McGovern and Borin Dental a copy of the Dental Materials Fact Sheet & Notice of Privacy Policy.

X ____________________ ____________________
Patient Signature *Date*

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge, I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X ____________________
Patient or Responsible Party

____
Date

Has any member of your family every been treated in our office?

❑ YES ❑ NO ____________________

Whom may we thank for referring you to our office?

____

METHOD OF PAYMENT

Responible party currently has an account with this office

❑ YES ❑ NO

❑ Payment in full each appointment (cash or personal check)

❑ Payment in full at each appointment (❑ VISA ❑ MC ❑ OTHER)

Card # ____________________ Exp. Date __________

❑ I wish to discuss the Dental Office's Financial Policy

FEE AGREEMENT

I understand that professional services are to be paid for, When rendered, unless other arrangements are made. I agree to pay interest at the rate of 18% per annum, on all unpaid balances, and I agree to pay the costs of any collection.
Furthermore, I acknowledge that any insurance coverage I have may pay all, part, or none of my treatment. I authorize insurance payments to be made directly to McGovern & Borin Dental.

X Signed ____________________ Date __________