

DR'S BUCHANAN, MARLEY AND HARROD

TODAY'S DATE _____

PATIENT INFORMATION:

NAME _____

PREFERRED NAME _____

SEX: M F AGE _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

HOME PHONE () _____

WORK PHONE () _____

MOBILE NUMBER () _____

EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PLEASE NAME OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE _____

SPOUSES NAME _____

DATE OF BIRTH _____ SSN _____

EMPLOYER _____

WORK PHONE NUMBER () _____

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE NOTIFY? _____

RELATIONSHIP _____

HOME PHONE NUMBER () _____

WORK PHONE NUMBER () _____

PERSON RESPONSIBLE FOR ACCOUNT:

NAME _____

RELATIONSHIP TO PATIENT _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE _____

GROUP NUMBER _____

INSURED'S INFORMATION:

NAME _____

DATE OF BIRTH _____ SSN _____

EMPLOYER _____

RELATIONSHIP TO PATIENT _____

DENTAL HISTORY:

PREVIOUS DENTIST _____

DATE OF LAST DENTAL VISIT _____

PLEASE LIST REASON FOR TODAY'S VISIT _____

ARE YOU CURRENTLY IN PAIN? _____NO _____YES

HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?

_____NO _____YES (PLEASE EXPLAIN)

DO YOU NOW HAVE OR HAVE YOU EVER EXPERIENCED DISCOMFORT OR PAIN IN YOUR JAW JOINT? (TMJ/TMD)

_____NO _____YES

YOUR CURRENT DENTAL HEALTH IS:

_____GOOD _____FAIR _____POOR

DO YOU LIKE TO SMILE? _____NO _____YES

WHAT WOULD YOU LIKE TO CHANGE ABOUT YOUR SMILE? _____

DO YOUR GUMS EVER BLEED? _____NO _____YES

HOW MANY TIMES EACH DAY DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____

TYPE OF BRISTLES IN YOUR TOOTH BRUSH

_____HARD _____MEDIUM _____SOFT

I UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN COMPLETE CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM ANY NECESSARY DENTAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH MY INFORMED CONSENT. THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

SIGNATURE: _____

DATE: _____

DR'S BUCHANAN, MARLEY AND HARROD

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

HIGH BLOOD PRESSURE	YES	NO
HEART DISEASE	YES	NO
HEART MURMUR	YES	NO
RHEUMATIC FEVER	YES	NO
CONGENITAL HEART DEFECT	YES	NO
PACEMAKER	YES	NO
STROKE	YES	NO
EXCESSIVE BLEEDING	YES	NO
ARTIFICIAL HEART VALVES	YES	NO
ANEMIA / BLOOD DISEASE	YES	NO
ARTIFICIAL BONES / JOINTS	YES	NO
ALLERGIES / HAYFEVER	YES	NO
ASTHMA	YES	NO
EMPHYSEMA	YES	NO
SINUS PROBLEMS	YES	NO
TUBERCULOSIS	YES	NO
RESPIRATORY PROBLEMS	YES	NO
CANCER	YES	NO
RADIATION / CHEMOTHERAPY	YES	NO
DIZZINESS	YES	NO
EPILEPSY	YES	NO
FAINTING	YES	NO
HEAD / NECK INJURIES	YES	NO
NERVOUS DISORDER	YES	NO
PSYCHIATRIC DISORDER	YES	NO
SEVERE HEADACHES	YES	NO
DRUG / ALCOHOL ABUSE	YES	NO
HEPATITIS	YES	NO
JAUNDICE	YES	NO
LIVER DISEASE	YES	NO
AIDS / HIV	YES	NO
STOMACH PROBLEMS	YES	NO
ULCERS	YES	NO
ARTHRITIS	YES	NO
DIABETES	YES	NO
EXCESSIVE FEVER BLISTERS	YES	NO

KIDNEY DISEASE	YES	NO
THYROID DISEASE	YES	NO
VENERAL DISEASE	YES	NO

DRUG ALLERGIES

PENICILLIN ALLERGY	YES	NO
ERYTHROMYCIN ALLERGY	YES	NO
TETRACYCLINE ALLERGY	YES	NO
CODIENE ALLERGY	YES	NO
ASPIRIN ALLERGY	YES	NO
DENTAL ANESTHETIC ALLERGY	YES	NO
LATEX ALLERGY	YES	NO

ANY OTHER DISEASES OR DRUG ALLERGIES NOT LISTED HERE?

PATIENTS MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?

YES NO

PHYSICIANS NAME _____

DATE OF LAST VISIT _____

LIST ANY SURGERIES _____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS?

YES NO

IF YES, PLEASE LIST _____

WOMEN ONLY

ARE YOU PREGNANT? YES NO

TAKING BIRTH CONTROL PILLS? YES NO

NURSING MOTHER? YES NO

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.