PLEASE PRINT

PATIENT INFORMATION

Patient's Last Name _____ Date: _____ Home Tel. ( ) _____

First _____ Middle Init. _____ Work Tel. ( ) _____

Mr. Mrs. Miss Ms. Date of Last Visit? _____ Cell Tel. ( ) _____

Home Address _____ City _____ Zip _____ How long? _____

Your Birth Date _____ Age _____ Soc. Security No. _____ Drivers License _____

Immediate Family Members
Who Are Our Patients _____

Your Employer _____ Occupation _____ Years With Firm _____

Employer Address _____ City _____ State _____

Spouse/Parent's Name _____ Address _____ City _____ State _____

Spouse/Parent's Employer _____ Soc. Security No. _____ Work Phone _____

Employer's Address _____
STREET CITY ZIP

Nearest Relative
Not Living With You _____ Home Tel. ( ) _____
NAME

_____ Work Tel. ( ) _____
STREET CITY ZIP

Physician _____ Tel. ( ) _____ Date of Last Physical _____
NAME CITY

Former Dentist _____ Why Did You Leave? _____ Date of Last Visit _____
NAME CITY ZIP

Whom may we thank for referring you to us? _____

I understand that the total bill is my debt and I assume the responsibility for payment of all amounts not paid by insurance company.

Signature _____

PATIENTS WITH DENTAL INSURANCE

Insured Person's Name _____ Soc. Sec. No. _____ Birth date _____

Union Name _____ Plan Name _____ Plan No. _____ Policy No. _____ Group No. _____

Does your spouse also have dental insurance? _____ (If yes, please give us the following:) Local _____

Union Name _____ Plan Name _____ Plan No. _____ Policy No. _____ Group No. _____

Spouses Soc. Sec. No. _____ Birth date _____ Did you bring your insurance form? _____

MEDICAL HISTORY

Please "X" either YES or NO box

YES	NO	YES	NO	YES	NO	YES	NO
☐ Do you prefer to save your teeth?	☐	☐ A recent physical exam	☐	☐ Tonsils out	☐	☐ Mastoid/ear infection	☐
☐ Is your general health good?	☐	☐ Any heart problems	☐	☐ Adenoids out	☐	☐ Measles	☐
On your previous dental visit....	☐	☐ High blood pressure	☐	☐ Anemia	☐	☐ Mumps	☐
☐ Were you given a local anesthetic?	☐	☐ Low blood pressure	☐	☐ Arthritis	☐	☐ Nephrosis	☐
☐ Were X-rays given?	☐	☐ Circulatory problems	☐	☐ Asthma	☐	☐ **RHEUMATIC FEVER**	☐
☐ Were home instructions given?	☐	☐ Nervous problems	☐	☐ Cerebral palsy	☐	☐ Scarlet fever	☐
☐ Were regular preventative visits made?	☐	☐ Radiation treatments	☐	☐ Chickenpox	☐	☐ Thyroid	☐
☐ Was there a history of dental decay?	☐	☐ Pain in region of ears	☐	☐ Chronic sinus	☐	☐ Tonsillitis	☐
☐ Were there any special problems?	☐	☐ Excessive Bleeding	☐	☐ Diabetes	☐	☐ Hepatitis	☐
☐ Do you dislike the look of your teeth?	☐	☐ Bleeding gums	☐	☐ Epilepsy	☐	☐ Jaundice	☐
Is there sensitivity in your mouth to:		☐ Food collect between teeth	☐	☐ Malignancies	☐	☐ Fainting or Dizziness	☐
☐ Heat ☐ Sweets ☐ Chewing		☐ Fluoride treatments	☐	☐ Stroke	☐	☐ V.D.	☐
☐ Cold ☐ Biting ☐ Previous injury		☐ Tooth sensitivity tests	☐	☐ Have you ever taken Fen-Phen or like diet medication?	☐	☐ AIDS	☐
☐ Do you have a history of:		☐ **Prosthetic joint replacement**	☐			☐ HIV	☐
☐ Nail biting							
☐ Hard Swallowing							
☐ Mouth breathing							
☐ Biting hard objects							

_____
MEDICAL HISTORY REVIEWED BY

DATE OF REVIEW _____

ALLERGY TO:

- ☐ Penicillin
- ☐ Local Anesthetics (i.e. novocaine)
- ☐ Codeine
- ☐ Nickel
- ☐ Latex
- ☐ Any other (specify:)

_____

Please describe any current medical treatment including drugs, impending operations, pregnancies, or other information the doctor should be aware of:

_____

_____

By my signature hereunder, I hereby consent to allow WILLIAM H. STANLEY to designate any dentist in attendance at the time of my appointments to perform the dental service necessary to my proper treatment.

Signature _____ Date _____

Permission is hereby granted to the doctor to perform any necessary dental work for this child. I do also authorize the administration of anesthetic as may be deemed advisable.

_____
SIGNATURE OF PARENT OR GUARDIAN