Mayer Family Dental

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PATIENT INFORMATION FORM

TODAY'S DATE _____

Last Name_____ First_____ MI_____ Nickname_____

Street Address_____

City_____ State_____ Zip_____

E-mail Address_____

Out of State Address_____

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth_____ Soc. Sec. #_____

Single _____ Married _____ Widowed _____ Divorced_____

Physician_____ Phone_____

Physician's Address_____

In Case of Emergency Notify (Not Living With You)

Last Name_____ First_____

Address_____ Phone_____

Dental Insurance Information

Primary Insurance_____ ID#_____

Address_____ City_____ ST_____ Zip_____

Phone_____ Name of Insured_____

Who is Financially Responsible for this Bill_____

I will be paying by Cash_____ Check_____ Credit Card_____

Please Complete the Following Information:

Where Are You Employed_____

Spouses Name_____

Where is S/He Employed_____ Phone_____

Who Can We Thank for Referring You To Us

Name_____ Phone_____

Address_____ City_____ ST_____ Zip_____

Yellow Pages _____ Newspaper_____ Drive By_____

Internet _____ Brochure_____ Other_____

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you ever had trauma to any of your teeth or facial trauma? ..... YES NO
5. Have you been a patient in the hospital during the past two years? ..... YES NO
6. Do you have swelling in the roof of your mouth? ..... YES NO
7. Have you noticed purplish color on your gums or cheeks? ..... YES NO
8. Do your gums bleed sometimes? ..... YES NO
9. Do you feel like you have dry mouth(xerostomia)? ..... YES NO
10. Have you been under the care of a medical doctor during the past two years? ..... YES NO
    If so why? _____
    _____
11. Have you taken any medicine or drugs during the past two years? ..... YES NO
    Are you now taking any medication, drugs or pills? ..... YES NO
    If yes, please list those drugs: _____
    _____
    _____
12. Have you ever taken Bisphosphonates: Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Bonefos or Zometa? ..... YES NO
13. Are you allergic or have you reacted adversely to any of the following medications: (Please **Circle** if yes)

Aspirin	Nitrous Oxide	Scopolamine	Penicillin
Codeine	Erythromycin	Nembutal/Seconal	Other Antibiotics
Demerol	Valium	Sulfa Drugs	(Novocaine or Xylocaine)

14. Are you aware of being allergic to any other medication or substance? ..... YES NO
    If yes, please list: _____
15. **Circle** any of the following which you have had or have at present:

Angina Pectoris (chest pain)	Asthma	Lupus	Fever Blister (Herpes)
Artificial Heart Valve	COPD: Emphysema/Chronic Bronchitis	Psoriasis	Shingles (Herpes Zoster)
Arteriosclerosis	Persistent Cough	Rheumatism	Venereal Disease
Congenital Heart Lesions/Conditions	Hay Fever	Rheumatoid Arthritis	(Gonorrhea, Herpes, Syphilis)
Heart Failure/Congestive Heart Failure	Sinus Trouble	Arthritis (osteoarthritis)	Chemotherapy (Cancer, Leukemia)
Heart Disease or Attack	Allergies or Hives	Artificial Joints (Hip, Knee, Shoulder)	Radiation (X-ray/Cobalt) Therapy
Heart Murmur	Tuberculosis (TB)	Anemia	Bell's Palsy (facial paralysis)
Heart Defibrillator	Diabetes: Type1/Type2/Insipidus	Blood Transfusion	Epilepsy or Seizures
Heart Pacemaker	Glaucoma	Bruise Easily	Fainting or Dizzy Spells
Heart Stent(s)	Kidney (Renal) Trouble	Hemophilia	Psychiatric Treatment
Heart Surgery	Sjögren Syndrome	Drug Addiction/History of Drug Use	Cancer
High Blood Pressure	Thyroid Disease	Hepatitis A (Infectious)	Osteoporosis
High Cholesterol	Yellow Jaundice	Hepatitis B (Serum)	Pain in Jaw Joints
Mitral Valve Prolapse	Crohn's Disease	Hepatitis C	Fibromyalgia
Rheumatic Fever	Gastroesphageal Reflux Disease (GERD)	HIV/AIDS	Alzheimer's Disease
Scarlet Fever	Ulcerative Colitis	Sickle Cell Disease	Neurological Disorders
Stroke	Ulcers	Cold Sores	Neuropathy
Taking Aspirin or blood thinners			Anxiety/ Nervousness
			Depression

16. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
17. Do your ankles swell during the day? ..... YES NO
18. Do you use more than 2 pillows to sleep? ..... YES NO
19. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
20. Do you ever wake up from sleep short of breath? ..... YES NO
21. Are you on a special diet? ..... YES NO
22. Has your medical doctor ever said you have cancer or a tumor? ..... YES NO
23. Do you have any disease, condition, or problem not listed? ..... YES NO
    Where _____ When _____
24. Do you get headaches (migraine, cluster, sinus,tension)? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes ❑ No If yes, what month? _____. Are you taking birth control pills? ❑ Yes ❑ No
Are you nursing or trying to get pregnant? ❑ Yes ❑ No

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, than may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine; due and payable at the time service is rendered. I further understand that a $1^1/_2$% finance charge (18% annually) will be collected costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent of Responsible Party _____ Relationship to Patient _____