INFORMATION REQUIRED FOR CASE HISTORY RECORD

THIS COMPLETE CONFIDENTIAL RECORD IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH
THIS FORM MUST BE FULLY COMPLETED

Patient's Name_______________ Name you liked to be called _______________

Home Phone_______________ Cell Phone _______________

Mailing Address_______________ City/State/Zip _______________ Drivers License # _______________

Soc. Sec. # _______________ Date of Birth_______________ Age _______________

Spouse/Parent Name _______________ Phone _______________

Your Employer _______________ Spouse/Parent Employer _______________

Who is Financially Responsible For This Bill? _______________

Guarantor's Soc. Sec. # _______________ Guarantor's Date of Birth _______________

Whom May We Contact In the Case of an Emergency _______________ Phone _______________

Nearest Relative Not Living With You _______________ Phone _______________

Nearest Friend Not Living With You _______________ Phone _______________

Whom May We Thank For Referring You To Us? _______________ Phone _______________

Please complete the Following Information If Patient Is Covered by DENTAL INSURANCE – PRIMARY

Name of Insurance Company _______________ Name of Group Dental Plan _______________

Subscriber_______________ DOB:_______________ Patient's Relationship to Employee _______________

*Soc. Sec. No. _______________ Employer _______________

Group No/Union Local/Policy No. _______________

SECONDARY DENTAL INSURANCE

Name of Insurance Company _______________ Name of Group Medical Plan _______________

Subscriber_______________ DOB:_______________ Patient's Relationship to Employee _______________

*Soc. Sec. No. _______________ Employer _______________

Group No/Union Local/Policy No. _______________

IF YOU HAVE ACCEPTABLE INSURANCE, PLEASE READ AND SIGN...

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical/dental benefits to physician for services rendered.

Signature_______________ Date_______________

I have read all the information on both sides of this sheet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. In the event my records and/or x-rays need to be forwarded to gain a second opinion, for insurance billing, for background information for physicians or specialist care, I give my permission to do so.

Signature _______________ Date_______________

Parent (if minor) _______________ Date _______________

I give my permission to discuss my medical and/or financial information with the following people:

Name _______________ Relationship _______________

Name _______________ Relationship _______________

Name _______________ Relationship _______________

CONTINUED ON REVERSE SIDE

HEALTH HISTORY

It is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the doctor or a member of the staff for assistance.

PHYSICIAN'S NAME ____________________

DENTIST'S NAME ____________________

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CIRCLE YOUR ANSWER TO EACH OF THE FOLLOWING QUESTIONS

1. Are you in good health? .... YES NO
2. Are you presently under a physician's care? .... YES NO
3. If so, for what condition? ____________________
4. Have you been hospitalized in the past 5 years .... YES NO
5. If so, for what reason? ____________________
6. What is your present oral surgery problem? ____________________

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7. Circle any of the conditions that you now have, or have had in the past.

HEART TROUBLE	HIGH BLOOD PRESSURE	LOW BLOOD PRESSURE	HIV/AIDS
HEART MURMUR	STROKE	RHEUMATIC FEVER	CANCER
ANGINA PECTORIS	TUBERCULOSIS	EMPHYSEMA	GLAUCOMA
HEPATITIS/JAUNDICE	ARTHRITIS	EPILEPSY/SEIZURES	ASTHMA
SINUS TROUBLE	ANEMIA	DIABETES	
KIDNEY DISEASE	ALCOHOL OR DRUG ABUSE	VENEREAL DISEASE	

OTHER CONDITIONS ____________________

8. Circle any of the following to which you are ALLERGIC.

LOCAL ANESTHETICS	SEDATIVES OR SLEEPING PILLS	ASPIRIN	PAIN RELIEVERS
PENICILLIN	OTHER ANTIBIOTICS	OTHER DRUGS ____________	

9. Circle any of the following types of medicines that you are taking at present.

ANTIBIOTICS	ANTICOAGULANTS (Blood Thinners)	CORTISONE (Steroids)	TRANQUILIZERS
INSULIN (or other Diabetes medicine)		BIRTH CONTROL PILLS	
HIGH BLOOD PRESSURE MEDICINE		DIGITALIS or (other Heart medicine)	
NITROGLYCERIN	OTHER MEDICINES ____________		

10. Are you a smoker? .... YES NO
11. Do you bleed easily or bleed for a long time after a cut or extraction? .... YES NO
12. Have you ever had any problem with past dental treatment? .... YES NO
13. If so, explain ____________________
14. Have you or any member of your family experienced any problems associated with general anesthesia? YES NO
15. If so, explain ____________________
16. FEMALES: Are you pregnant? .... YES NO
17. If so, in which month are you? ____________________
18. Is there any information, not given above, which you think is important for proper health care treatment in your case?

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I CONFIRM AS TRUE THE ABOVE HEALTH HISTORY INFORMATION.

Patient's Signature ____________________ Parent or guardian ____________________

. . . . F O R D O C T O R ' S U S E . . . .

CHANGES IN HEALTH ____________________ DATE ____________

CHANGES IN HEALTH ____________________ DATE ____________

REVIEWED BY ____________________ DATE ____________