PATIENT INFORMATION SHEET

PATIENT Mr. Mrs. Ms. Dr. ____ ________________________ ______
Last First M.I.

Age ____ Date of Birth ____/____/______

Address____ City________________________ State___ Zip_______

Home phone (_____) _____-________ Cell phone (_____) _____-_______ Work phone (_____) _____-_______

Occupation ____________________ Social Security # _____-____-______ Drivers License # ________________

Employed by ______________________________________ If Student, where? ____________________________

Spouse's name ______________________________ Soc. Sec. #_____-____-______ Date of Birth___/___/______

Occupation ______________________ Employed by ____________________ Work phone (____) ____-______

Who is financially responsible for this account? ___________________________ Home phone (____) ____-______

Person to contact in case of emergency ____________________ Relationship ________ Phone (____) ____-______

Patient's dentist ______________________ Phone (____) ____-______ Referred by _______________________

Patient's physician _______________________ Last physical exam ___/___/______ Phone (____) ____-______

Dental insurance ____________________ Policy # __________________ Subscriber ______________________

Medical insurance ____________________ Policy # Subscriber ______________________

(**IF MINOR**) Parent's name _________________________ Soc. Sec. #____-____-______ Date of Birth________

Occupation ______________________ Employed by ____________________ Work phone (____) ____-______

PATIENT HEALTH HISTORY Please answer all questions. Don't understand? Aren't sure? Please leave it BLANK.

Your Height ________________________________ Your Weight __________________________

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Have you been hospitalized or had a serious illness in the last three years? Please explain:
   ____
4. YES NO Are you being treated by a physician now? If so, for what?
   ____
5. YES NO Have you had problems with prior dental treatment? Please explain:
   ____
6. YES NO Are you in pain now?

HAVE YOU EXPERIENCED?

7. YES NO Chest pain or angina?
8. YES NO Swollen ankles?
9. YES NO Shortness of breath?
10. YES NO Recent weight loss, fever, night sweats?
11. YES NO Persistent cough, coughing up blood?
12. YES NO Bleeding problems, bruising easily?
13. YES NO Sinus problems?
14. YES NO Difficulty swallowing?
15. YES NO Anxiety attacks?
16. YES NO Frequent vomiting, nausea?
17. YES NO Difficulty urinating, blood in urine?
18. YES NO Dizziness?
19. YES NO Ringing in ears?
20. YES NO Headaches?
21. YES NO Fainting spells?
22. YES NO Blurred vision?
23. YES NO Seizures?
24. YES NO Excessive thirst?
25. YES NO Frequent urination?
26. YES NO Dry mouth?
27. YES NO TMJ problems?
28. YES NO Joint pain, stiffness?

DO YOU HAVE, OR HAVE YOU EVER HAD?

29.	YES	NO	Heart murmurs?	36.	YES	NO	Bleeding or clotting problems?
30.	YES	NO	Heart attack, heart disease, heart defects?	37.	YES	NO	Hepatitis A, B, or C, jaundice?
31.	YES	NO	High blood pressure?	38.	YES	NO	Liver disease or tumor?
32.	YES	NO	Delayed healing?	39.	YES	NO	Blood transfusions?
33.	YES	NO	Bypass surgery?	40.	YES	NO	Anemia?
34.	YES	NO	Prosthetic heart valve?	41.	YES	NO	Stomach problems, ulcers?
35.	YES	NO	Pacemaker?	42.	YES	NO	Arthritis, rheumatism?

DO YOU HAVE, OR HAVE YOU EVER HAD?

43.	YES	NO	TB, emphysema, asthma, lung diseases?	52.	YES	NO	Diabetes?
44.	YES	NO	Allergies: food, drugs, latex products?	53.	YES	NO	Kidney, bladder disease?
45.	YES	NO	Allergies: local or general anesthetics?	54.	YES	NO	Surgeries?
46.	YES	NO	Artificial joint?	55.	YES	NO	Hospitalization?
47.	YES	NO	Tumors, cancer?	56.	YES	NO	Eye diseases?
48.	YES	NO	Chemotherapy or radiation treatments?	57.	YES	NO	Frequent skin infections?
49.	YES	NO	Psychiatric care?	58.	YES	NO	AIDS or HIV?
50.	YES	NO	Substance abuse problems?	59.	YES	NO	Herpes?
51.	YES	NO	Thyroid, adrenal disease?	60.	YES	NO	Venereal disease?

ARE YOU USING, OR HAVE YOU EVER USED?

61.	YES	NO	Tobacco in any form?	63.	YES	NO	Recreational drugs?
62.	YES	NO	Alcohol?	64.	YES	NO	ANY diet drugs?

WHAT DRUGS ARE YOU TAKING? (PLEASE LIST ALL PRESCRIPTION & NON-PRESCRIPTION DRUGS)
(Example: blood thinners, blood pressure meds, antibiotics, aspirin, herbs)

____

____

____

WOMEN ONLY:

65.	YES	NO	Are you pregnant or nursing now?	66.	YES	NO	Could you be pregnant?

ALL PATIENTS:

67. YES NO Do you have any other diseases or medical conditions NOT listed on this form? If so, please list:

____

68. YES NO Do you need to pre-medicate with antibiotics for ANY reason? (for example, heart condition, heart valve, prosthetic joint?) If so, why?

____

To avoid misunderstandings regarding dental and medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient, AND THAT CHARGES ARE TO BE PAID FOR AT THE TIME OF SERVICE. We will prepare the necessary forms or reports to help you obtain reimbursement from your insurance companies. WE DO NOT RENDER OUR SERVICES ON THE ASSUMPTION THAT YOUR INSURANCE COMPANY WILL PAY OUR FEES.

I have, to the best of my knowledge, answered every question completely and accurately. I will inform Dr. Mestman of any changes in my health and/or medications.

____ ____ / ____ / __________

Signature of patient (or parent, if patient is a minor) Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given an opportunity to read this oral surgery practice's "Notice of Privacy Practices". I further acknowledge that a copy of the current notice is posted on our web site and in the reception area, and that I will be offered an opportunity to read an updated copy of "Notice of Privacy Practices," should any changes be made in the future.

____________________________ ___________________________ ____ / ____ / __________

Name (printed) *Signature* Date

If not signed by the patient, please indicate relationship to patient ______ Parent or guardian (if patient is a minor)

______ Guardian or conservator of an incompetent patient