PATIENT INFORMATION SHEET

PATIENT

Mr. Mrs. Ms. Dr. _____ _____ _____
Last First M.I.

Age _____ Date of Birth ____/____/_____

Address_____ City_____ State___ Zip_____

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

Occupation _____ Social Security # _____-____-_____

Drivers License # _____ Employed by _____

If Student, where? _____

Spouse's name _____ Social Security #_____-____-_____

Date of Birth___/___/_____ Occupation _____

Employed by _____ Work phone (____) ____-_____

Person financially responsible for account? _____ Phone (____) ____-_____

In case of emergency contact _____ Phone (____) ____-_____

Relationship _____

Patient's dentist _____ Phone (____) ____-_____

Referred by _____

Patient's physician _____ Phone (____) ____-_____

Last physical exam ___/___/_____

Dental insurance _____ Policy # _____ Subscriber _____

Medical insurance _____ Policy # _____ Subscriber _____

IF A MINOR

Parent's name _____ Soc. Sec. #_____-_____-_____

Date of Birth___/___/_____ Employed by _____ 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?	18.	YES	NO	Dizziness?
8.	YES	NO	Swollen ankles?	19.	YES	NO	Ringing in ears?
9.	YES	NO	Shortness of breath?	20.	YES	NO	Headaches?
10.	YES	NO	Recent weight loss, fever, night sweats?	21.	YES	NO	Fainting spells?
11.	YES	NO	Persistent cough, coughing up blood?	22.	YES	NO	Blurred vision?
12.	YES	NO	Bleeding problems, bruising easily?	23.	YES	NO	Seizures?
13.	YES	NO	Sinus problems?	24.	YES	NO	Excessive thirst?
14.	YES	NO	Difficulty swallowing?	25.	YES	NO	Frequent urination?
15.	YES	NO	Anxiety attacks?	26.	YES	NO	Dry mouth?
16.	YES	NO	Frequent vomiting, nausea?	27.	YES	NO	TMJ problems?
17.	YES	NO	Difficulty urinating, blood in urine?	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. Strahs 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, if patient is incompetent