PATIENT INFORMATION

Date ______________________________

Patient Name ____
Last First Middle

Address ____
Street City State Zip

Home Phone ______________________ Birthdate __________ Social Security # ______________________

If Patient is a Minor give parent's or guardian's name ______________________

Whom may we thank for referring you to our office? ______________________

RESPONSIBLE PARTY INFORMATION

Patient Name ____
Last First Middle

Residence ____
Street City State Zip

Mailing Address ____
Street City State Zip

How Long at this Address ______________ Home Phone ______________________ Work Phone ______________________

Previous Address (if less than 3 yrs.) ____
Street City State Zip

Social Security # ______________________ Birthdate ______________ Relationship to Patient ______________________

Employer ______________________ Occupation ______________________ No. Years Employed __________

Spouse's name ______________________ Relationship to Patient______________________

Employer ______________________ Occupation ______________________ No. Years Employed __________

Social Security # ______________________ Birthdate __________ Work Phone ______________________

INSURANCE INFORMATION

Insured's Name ______________________ Insured's Soc. Sec. # ______________________

Insurance Company ______________________ Group # ______________ Local # ______________

Insurance Co. Address ____

Do You Have Dual Coverage? ☐ Yes ☐ No If Yes, fill out information for second insurance below.

Insured's Name ______________________ Insured's Soc. Sec. # ______________________

Insurance Company ______________________ Group # ______________ Local # ______________

Insurance Co. Address ____

Insured Employer ____

EMERGENCY INFORMATION

Name of nearest relative not living with you ______________________

Complete Address ____

Phone # ____

A consumer credit report may be ordered in connection with fee payment arrangements or subsequently with update, renewal or extension of credit. Upon your request, you will be informed whether or not a consumer credit report was ordered, and if it was, you will be given the name and address of the consumer reporting agency that furnished that report.

Date ______________________Signature____

Witness____

Patient Name ______________________________

HEALTH HISTORY

1. Are you having discomfort at this time? ______________________________

2. Have you been a patient in the hospital in the past two years? ______________________________

3. Have you been seen by a medical doctor in the past two years? ______________________________

   If Yes, Reason: ______________________________

   Physician's Name ______________________________ Phone ______________________________

   Address: ______________________________

4. Have you taken any medicine, hormones or vitamins during the past two years? ❑ Yes ❑ No

   If Yes, please list: ______________________________

5. Are you allergic or have you reacted adversely to any of the following:

   - ❑ Aspirin
   - ❑ Darvon
   - ❑ Codeine
   - ❑ Percodan
   - ❑ Sulfa Drugs
   - ❑ Penicillin
   - ❑ Erythromycin
   - ❑ Tetracycline
   - ❑ Other Antibiotics
   - ❑ Metal Allergy
   - ❑ Valium
   - ❑ Nitrous Oxide
   - ❑ Local Anesthetic
   - ❑ (Xylocaine/Novocaine)
   - ❑ Latex

6. Are you allergic to any other medications or substances? ❑ Yes ❑ No What?______________________________

7. Circle any of the following which you have had or have at present:

   Cancer
   Heart Failure
   Heart Disease or Attack
   Heart Abnormalities
   Angina Pectoris
   High Blood Pressure
   Heart Murmur
   Rheumatic Fever
   Heart Surgery
   Artificial Joints
   Artificial Heart Valve
   Stroke
   Anemia
   Kidney Trouble
   Emphysema
   Cough
   Tuberculosis (TB)
   Asthma
   Hay Fever
   Allergies or Hives
   Pain in Jaw Joints
   Headaches
   Thyroid Disease
   Arthritis
   Rheumatism
   Diabetes
   Serum Positive—A.I.D.S.
   A.I.D.S.
   Hepatitis A (infectious)
   Hepatitis B (serum)
   Liver Disease/Jaundice
   Sinus Trouble
   Blood Transfusion, year ______________
   Drug Addiction
   Hemophilia
   Venereal Disease
   Epilepsy/Seizures
   Fainting/Dizzy Spells
   Ulcer
   Psychiatric Treatment

8. 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? ❑ Yes ❑ No

9. Have you lost or gained more than 10 pounds in the past year? ❑ Yes ❑ No

10. Do you have any disease, condition, or problem not listed? ❑ Yes ❑ No

11. WOMEN: Are you pregnant? ❑ Yes ❑ No If Patient yes, what month? ______________________________

12. Do you smoke? ______________________________

13. Do you snore or have any other airway problems that affect your sleep? ❑ Yes ❑ No ❑ Maybe

Patient Signature______________________________ Date______________________________

Parent/Responsible Party______________________________ Relation to Patient______________________________