PATIENT INFORMATION

DATE _____

FIRST NAME _____ M _____ LAST _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT'S PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____

DATE OF BIRTH _____ AGE _____ ❑ MALE ❑ FEMALE

SOC. SEC. # _____ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW

EMAIL ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE _____

DENTIST _____
First Name Last Name

PHYSICIAN _____
First Name Last Name

DATE OF LAST PHYSICAL _____

WHO REFERRED YOU TO THIS PRACTICE _____

PLEASE PRESENT ALL INSURANCE CARDS, FORMS, AND ID'S

POLICY HOLDER RESPONSIBLE FOR ACCOUNT ABOVE

PRIMARY DENTAL INSURANCE COMPANY _____

FIRST NAME _____ M _____ LAST _____

RELATIONSHIP TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

DATE OF BIRTH _____ AGE _____ ❑ MALE ❑ FEMALE

SOC. SEC. # _____ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW

PAYMENT IS DUE AT THE TIME OF SERVICE. **If we are filing insurance, you will need to pay a portion. This must be done BEFORE services are rendered. ALL ACCOUNTS MUST BE PAID WITHIN 30 DAYS.**

OVER

PLEASE ANSWER EACH QUESTION

1. Do you carry on normal activities ❑ Yes ❑ No Height _____ Weight _____

2. Would you say your health is ❑ Excellent ❑ Good ❑ Fair ❑ Poor

3. Are you now or have you in the past 5 years been treated by a physician ❑ Yes ❑ No
   If Yes, for what _____

4. Have you ever been hospitalized? ❑ Yes ❑ No For what? _____
   _____

5. Have you ever had a serious injury, illness or condition? ❑ Yes ❑ No
   Explain _____

6. List all medications that you take (include Coumadin, blood thinners, aspirin, birth control pills, vitamins, herbal medicines, over the counter) _____
   _____
   _____
   _____

7. Are you currently being treated for pain management? ❑ Yes ❑ No
   If yes, list medication(s) and prescribing doctor _____

8. List allergies to medications including Penicillin, Aspirin, Novocaine (Other): _____
   _____

9. Have you ever had a reaction to or problem with local anesthesia (numb gums)? ❑ Yes ❑ No

10. Have you ever had a reaction to or problem with general anesthesia (go to sleep)? ❑ Yes ❑ No

11. Have you ever bled excessively after extractions of teeth or any other surgery? ❑ Yes ❑ No

12. Do you use cocaine, heroin, other street or recreational drugs? ❑ Yes ❑ No

13. Do you use tobacco or marijuana? ❑ Yes ❑ No How long? _____ How much? _____

14. Have you had anything to eat or drink in the past 8 hours? ❑ Yes ❑ No

CHECK YES OR NO. HAVE YOU HAD ANY OF THE FOLLOWING?

❑ Yes ❑ No Heart Condition
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Stroke
❑ Yes ❑ No Heart Valve Replacement
❑ Yes ❑ No Heart Attack
❑ Yes ❑ No Mitral Valve Prolapse
❑ Yes ❑ No Joint Replacement
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Kidney Disease
❑ Yes ❑ No Anemia
❑ Yes ❑ No Psychiatric Treatment
❑ Yes ❑ No HIV Positive or AIDS
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Asthma
❑ Yes ❑ No Liver Disorder

❑ Yes ❑ No Thyroid
❑ Yes ❑ No Headaches
❑ Yes ❑ No Pregnant now, weeks:_____
❑ Yes ❑ No Bleeding Disorders
❑ Yes ❑ No TB
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Arthritis
❑ Yes ❑ No TMJ
❑ Yes ❑ No Cancer
❑ Yes ❑ No Convulsions or Seizures
❑ Yes ❑ No Dizziness, Fainting
❑ Yes ❑ No Cough, Cold, Sinus Trouble
❑ Yes ❑ No Snoring, Sleep Apnea
❑ Yes ❑ No Alcohol/Chemical Dependence
❑ Yes ❑ No Chemo/Radiation Therapy
❑ Yes ❑ No Circulatory Problems

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Drs. Strull & Strull, PSC or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to the release of information for insurance purposes and authorize the responsible third party to pay directly Drs. Strull & Strull, PSC, insurance benefits due me for services rendered. I also understand that I am responsible for any unpaid balance due Drs. Strull & Strull, PSC, plus any and all costs incurred by Drs. Strull & Strull, PSC including reasonable attorney fees, in the collection of said unpaid balance.

Patient Signature _____ Date _____

Witness _____ Date _____

Doctor _____ Date _____