PATIENT INFORMATION

DATE ____________

NAME ____________ BIRTHDATE ____________

ADDRESS ____________ Male ______ Female ______

CITY ____________ STATE ________ ZIP ____________

HOME PHONE ____________ WK PHONE ____________

CELL PHONE ____________ E-MAIL ____________

PATIENT STATUS: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

PATIENT'S OR PARENT'S EMPLOYER ____________

BUSINESS ADDRESS ____________

SPOUSE OR PARENT'S NAME ____________

EMPLOYER ____________ WK PHONE ____________

IF PATIENT IS A STUDENT NAME OF SCHOOL/COLLEGE ____________

WHOM MAY WE THANK FOR REFERRING YOU? ____________

EMERGENCY CONTACT ____________

RELATIONSHIP ____________ PHONE ____________

REASON FOR VISIT ____________

PREVIOUS DENTIST ____________ LAST DENTAL VISIT ____________

What if any, Problems do you have with Dental Treatment? (i.e. Dislike sound of drill) ____________

____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________

RELATIONSHIP TO PATIENT ____________

ADDRESS ____________ CITY, STATE, ZIP ____________

DRIVER'S LICENSE # ____________ SS # ____________

BIRTHDATE ____________ HM PHONE ____________ WK PHONE ____________

INSURANCE INFORMATION

NAME OF INSURED ____________

RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________ SS # ____________ ID # ____________

NAME OF EMPLOYER ____________ WK PHONE ____________

ADDRESS OF EMPLOYER ____________

INSURANCE COMPANY ____________ GROUP # ____________

INS. CO. ADDRESS ____________

MEDICAL HISTORY/INFORMATION

MEDICAL DOCTOR ______________________ PHONE #__________

List all medications you are currently taking, and the reason for taking them: ______________________

____

ALLERGIC TO: ❑ None ❑ Latex ❑ Codeine ❑ Antibiotics (list below) ❑ Dental anesthetics (list below)

____

Please list **All Other Allergies** ______________________

Has your cardiologist, surgeon or other doctor ever told you to take an antibiotic before any dental treatment? **Y / N**

If yes, why were you prescribed a pre-medication and what is the medication prescribed? ______________________

____

Please list any Surgeries or Hospitalizations ______________________

____

____

Are you pregnant or nursing? **Y / N** Due date__________ Are you taking birth control pills? **Y / N**

Do you use tobacco? **Y / N** Type: Smoke/Chew/Dip How often?__________ For how many years? __________

Do you have headaches, back pain or neck pain? **Y / N** How often?__________ Severity? __________

Do you have or have you had any of the following conditions? (Circle **Y** or **N**)

Y / N	Heart Attack / Stroke	**Y / N**	Thyroid Problems	**Y / N**	Cancer or Tumors
Y / N	Cosmetic Surgery	**Y / N**	Heart Surg. / Pacemaker	**Y / N**	Kidney Problems
Y / N	Shingles	**Y / N**	X-ray or Cobalt Treatment	**Y / N**	Heart Murmur
Y / N	Liver Problems	**Y / N**	Hepatitis	**Y / N**	Chemotherapy
Y / N	Rheumatic Fever	**Y / N**	Respiratory Problems	**Y / N**	HIV / AIDS / ARC
Y / N	Asthma	**Y / N**	Mitral Valve Prolapse	**Y / N**	Sinus Problems
Y / N	Arthritis / Rheumatism	**Y / N**	Difficulty Breathing	**Y / N**	Artificial Heart Valves
Y / N	Stomach Problems / Ulcers	**Y / N**	Artificial Bones / Joints	**Y / N**	Diabetes
Y / N	Heart Disease	**Y / N**	Psychiatric Problems	**Y / N**	Emphysema
Y / N	Leukemia	**Y / N**	Congenital Heart Defect	**Y / N**	Venereal Disease
Y / N	Fainting / Seizures / Epilepsy	**Y / N**	Anemia	**Y / N**	Chest Pains
Y / N	Alcohol / Drug Abuse	**Y / N**	Glaucoma	**Y / N**	High Blood Pressure
Y / N	Scarlet Fever	**Y / N**	Tuberculosis (TB)	**Y / N**	Hypoglycemia
Y / N	Bleeding Problems	**Y / N**	Nervousness	**Y / N**	TMJ / TMD Problems

Please list any other medical conditions not listed above:______________________

____

____

I authorize the staff at Curtis Marc Standish, D.M.D., P.A. to perform any necessary services needed during diagnosis and treatment. I also authorize Curtis Marc Standish, D.M.D., P.A. to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsbility to inform this office of any changes to the information that I have provided.

Signature: ______________________ **Date** __________

Please check one: ❑ Adult Patient ❑ Parent or Guardian ❑ Spouse