PATIENT INFORMATION

Patient Name____

Patient Date of Birth________________________________ Age ______________

Home Address________________________________ Apt # ______________
Please not billing and/other correspondence will be sent to this address

City/State/Zip____

Home # ________________________Work #________________________
**It will be necessary for us to contact you at these numbers concerning appointments, treatm ent or billing*

Cell # ________________________Pager #________________________
**Please be aware that a cell phone is NOT a secure or private line*

Patient Employer________________________Occupation________________________

Patient Social Security #____

Patient Driver's License #________________________State________________

*If alternate address or phone numbers are necessary please indicate________________________

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Any messages left by our office will be for you to contact us

Nearest Relative (not living with you)________________Relationship________________
** It may be necessary to leave a message with this individual*

Phone Number____

Responsible Part for Account________________________Date of Birth________________________

Spouse/Responsible Party's Employer________________Position________________________

Spouse/Responsible Party's Phone #________________Work #________________________

Spouse/Responsible Party's Social Security #________________________________

Spouse/Responsible Party's Driver License #________________________State________________

Purpose of Appointment____

Referred by____

General Dentist________________________Orthodontist/Other Specialist________________
Please be aware it may be necessary for us to contact you doctor/dentist regarding treatment, referral or additional billing information

Family members previously treated____

Patient **Dental** Insurance Carrier________________________________Group/Policy____________

Insurance Carrier Phone Number____

Patient **Medical** Insurance Carrier________________________________Group/Policy____________

Insurance Carrier Phone Number____

I hereby authorize Dr. Holcomb to release any information acquired in the course of my examination or treatment as necessary.

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Patient (or legal guardian's) signature ***Date***

Medical Questionnaire

Are you now, or have been under the care of a physician, including a psychiatrist, during the past two years?
If so, for what were you treated for? ____ Yes ___ No ___

Have you been a patient in a hospital in the past two years? If so, what were you hospitalized for? _________________
____ Yes ___ No ___

Have you had any surgical procedures in the past? If so, please describe: ______________________________________ Yes ___ No ___
____
If surgery was performed, please list name of surgeon: ____.

Have you taken cortisone, hormone or any other steroidal medications (i.e. Decadron, Dexamethasone, Medrol pak, Methylprednisolone, Prednisone)? If so, please list name of medication and date last taken: _______________________ Yes ___ No ___

Have you ever had a reaction during, or following dental treatment or oral surgery? If so, please describe: Yes ___ No ___
____

Have you had a reaction to any medicine(s) (i.e. Aspirin, Codeine, Penicillin, Sulfa, etc.)? If so, please list: Yes ___ No ___
____

Do you have hay fever or any allergies? If so, please describe: ____ Yes ___ No ___

If you cut yourself or have teeth/tooth extracted do you bleed so much that you have to see a doctor to have the bleeding stopped? If so, please describe: ____ Yes ___ No ___

Are you taking blood thinners (i.e. Coumadin, Warfarin, Plavix, Aspirin)? If so, please list medication(s): ___________ Yes ___ No ___

Have you taken any type of Bisphosphonates (i.e. Risedronate, Actonel, Alendronate, Fosamax, Ibandronate, Boniva, Pamidronate, Aredia, Zoledronate, Zometa, Etidronate, Didrocal, Skelid)? These medications are usually prescribed to treat osteoporosis and some types of cancer. If so, please list name of medication and date last taken: ____________________________________ Yes ___ No ___

List medicines or drugs (include herbals) that you have taken during the past year and for what: ___________________________________
____

Check any of the following, which you have or have had:

___ Congenital Heart Disease	___ High Blood Pressure	___ Cancer (type_________________________)
___ Stroke (date____________)	___ Diabetes (Insulin or Oral Meds)	___ Radiation/Chemotherapy (date__________)
___ Heart attack (date____________)	___ Kidney or bladder trouble	___ Thyroid Disease
___ Shortness of breathe	___ Nervous Disorders	___ Ulcers
___ Chest pain, angina	___ Seizures (Epilepsy)	___ Blood Disease
___ Irregular heart beat	___ Asthma	___ Anemia
___ Replacement of heart valve (date ______)	___ Emphysema	___ Hepatitis (Yellow Jaundice)
___ Heart Murmur	___ Pneumonia	___ Syphilis or Venereal Disease
___ Rheumatic Fever	___ Tuberculosis	___ HIV Positive
___ Mitral Valve Prolapse	___ Arthritis	___ A.I.D.S.

Do you faint easily? __________ Do you get short of breath easily? __________ Do you smoke? ________ How much? ____________
Do you have sores or growths in your mouth? __________ Have you ever had any serious injuries to your face or jaws? ____________
Do you have any disease, condition or problem not listed above that you think we should know about? If so, please describe:
____
Do you have any impairment? If so, please describe: ____

Women: Are you taking birth control pills? _______________ Are you pregnant?______________ Due date:______________________
Please be advised that when taking most antibiotics they will affect birth control medication by making it ineffective resulting in pregnancy unless other preventive methods are taken for one complete cycle.

Approximate weight __________________________ Approximate height ___________________________ Age _________________

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Patient's (or legal guardian's) signature   Date