

HEALTH INFORMATION AND HISTORY

PATIENTS NAME _____

How would you describe your present health - EXCELLENT GOOD FAIR POOR NOT SURE

YES NO

_____ _____ Has there been any change in your general health in the past year

_____ _____ Have you had any serious illness operation or hospitalization in the past five years

If yes, please explain _____

_____ _____ Are you currently taking medication? If yes, please list all the medications including over-the-counter _____

_____ _____ Have you ever had any type of joint replacement? (Knee, hip, etc.)

_____ _____ Heart Ailment (Mitral valve prolapse, heart murmur, pacemaker?)

_____ _____ Are you allergic to any medications, latex, anesthetic? If yes, what? _____

_____ _____ Do you use any kind of tobacco? If yes, what type _____

_____ _____ Are you currently wearing or supposed to be wearing a CPAP device while sleeping?

Circle all of the following that you may have had in the past or that currently apply to you:

- | | |
|------------------------------|-----------------------------------|
| Diabetes | Sore or tired jaw |
| Epilepsy | Difficulty opening wide |
| High blood pressure | Frequent Headaches |
| Low blood pressure | Migraine/cluster headaches |
| Respiratory disease (Asthma) | Snoring |
| Hepatitis | Choke/gasp for air while sleeping |
| Prolonged bleeding | Sleep Apnea |
| Chest pain | Sinus Trouble |
| Tachycardia | G I ulcers |
| History of Cancer | Anorexia or bulimia |
| Stroke | Pregnant/nursing |

Emergency contact name and number _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully as the best of my knowledge.

I authorize Steven M Green DDS to perform all recommended treatment usually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Steven M. Green DDS choose and employ such assistants as deemed fit to provide recommended treatment.

Patient/legal guardian **Date**

Patient Information Form

FULL NAME _____

ADDRESS _____

STATE _____ ZIP CODE _____ SS# _____ BIRTHDAY _____

HOME# _____ CELL# _____ WORK# _____

E-MAIL ADDRESS _____

REFERRED BY _____

SPOUSES NAME _____

DENTAL INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY _____ PHONE# _____

SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____

SINCE _____

SUBSCRIBERS BIRTHDAY _____ SUBSCRIBERS SS _____

GROUP _____ IDENTIFICATION _____

NAME OF EMPLOYER _____

SECONDARY

INSURANCE COMPANY _____ PHONE# _____

SUBSCRIBER NAME _____

RELATIONSHIP TO PATIENT _____

SINCE _____

SUBSCRIBERS BIRTHDAY _____ SUBSCRIBERS SS _____

GROUP _____ IDENTIFICATION _____

NAME OF EMPLOYER _____

We must have a copy of your insurance card. Information must be correct to file to insurance company.
This is the patient's responsibility.

Signature of patient or legal guardian

Date