

SANFORD L. RATNER, D.D.S. • MONTY C. WILSON, D.D.S.

Have you ever been a patient in this office before? YES NO Approximate Date: _____

PATIENT: _____ **TODAY'S DATE** _____
LAST FIRST MIDDLE

S.S. #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Apt. # _____ Date of Birth: _____ Age: _____ Sex: M F

City: _____ State: _____ Zip Code: _____

CIRCLE ONE: MISS MRS. MS. MR. DR. REV. CHILD Driver's Lic. #: _____

CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED E-Mail: _____

If student, school attending: _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ Phone: _____

**IF PATIENT IS MARRIED
COMPLETE THIS PORTION**

Spouse's Name: _____

Spouse's Occupation: _____ Soc. Sec. No.: _____

Spouse's Employer: _____ Phone: _____

Address: _____ City: _____

**IF PATIENT IS A SINGLE
MINOR (under 21 years)
COMPLETE THIS PORTION**

Parent or Guardian's Name: _____

Person Financially Responsible: _____ Soc. Sec. No.: _____

Occupation: _____ Employer: _____

Address: _____ City: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

ALL PATIENTS

Dentist: _____ D.D.S.

City: _____ Phone: _____

REFERRED BY:

Orthodontist: _____ D.D.S.

City: _____ Phone: _____

Approximate date of last visit: _____

INSURANCE INFORMATION

DENTAL INSURANCE INFORMATION

MEDICAL INSURANCE INFORMATION

PRIMARY

SECONDARY

PRIMARY

SECONDARY

Name of Insurance Co.: _____

Name of Insurance Co.: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Name of Policy Holder: _____

Name of Policy Holder: _____

S.S. #: _____ DOB: _____

S.S. #: _____ DOB: _____

I.D. No.: _____

I.D. No.: _____

Group No.: _____

Group No.: _____

ASSIGNMENT AND RELEASE: I hereby authorize payment directly to the undersigned Dentist of the Medical/Dental Insurance benefits otherwise payable to me. I am financially responsible for any charges not covered by this authorization.

Signed (Patient/Insured Person) _____

PLEASE TURN AND COMPLETE HEALTH HISTORY RECORD ON REVERSE SIDE.

HEALTH HISTORY

It is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the doctor or a member of staff for assistance.

Medical Doctor's Name: _____ Phone No.: _____

Address: _____

Date of last Physical Examination: _____

Are you in good health? _____

Check your answer to each of the following questions. If yes, please explain.

1. Are you presently under a physician's care? YES NO
2. If so, for what condition? _____ YES NO
3. Have been hospitalized in past 5 years? YES NO
4. If so, for what reason? _____
5. What is your present oral surgery problem? _____

6. Are you a smoker? YES NO
7. Do you bleed easily or bleed for a long time after a cut or extraction? YES NO
8. Have you ever had problem with the past dental treatment? YES NO
9. If so, explain how _____
10. Have you or any member of your family experienced any problems associated in general anesthesia or "Twilight Sleep" YES NO
 If so, explain how _____

Please check mark the box "YES" or "NO" to indicate if you have had any of the following:

- | | | | | | | | | |
|---|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|
| AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Fainting or dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Psychiatric Care | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Radiation Treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Arthritis, Rheumatism | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Headaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Respiratory Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Artificial Heart Valves | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Murmur | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Rheumatic Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Artificial Joints | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Scarlet Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Shortness of Breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Back Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Type _____ | | | Sinus Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding abnormally, with
extractions or surgery | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Herpes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Skin Rash | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blood disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | High Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Special Diet | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO | HIV Positive | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Drug/Alcohol Abuse | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Jaundice | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Swelling of feet
or Ankle | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chemotherapy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Jaw Pain | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Circulatory Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tonsillitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Congenital Heart Lesions | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Liver Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cortisone Treatments | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Low Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tumor or Growth on
Head or Neck | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cough, persistent or bloody | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mitral Valve Prolapse | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ulcer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Nervous Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Veneral Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Emphysema | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Pacemaker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Weight Loss,
unexplained | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you wear
contact lenses? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Women:
Are you pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |
| Epilepsy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Due Date _____ | | | | | |
| | | | Are you nursing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |

MEDICATIONS

List medication you are currently taking: _____

Have you ever taken Fosomax/Actinel/Boniva? YES NO

Have you ever taken Fen-Phen? YES NO

Have you ever taken Redux? YES NO

When were your last dental x-rays? _____

ALLERGIES

Aspirin

Barbiturates (Sleeping Pills)

Codeine

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

Other _____

PATIENT'S / PARENT'S SIGNATURE _____

DATE _____

DOCTOR'S SIGNATURE _____

DATE _____

CHANGES IN HEALTH _____ DATE _____

REVIEWED BY: _____ DATE _____